Andrew M. Cuomo, 56th Governor of the State of New York

Statement for the Congressional Record

Before we begin, I think it's important to recognize that to date over 1.2 million Americans have died from COVID – 80,000 thousand in New York – and behind every number is a face, and a name, and a family that is suffering, and that is a painful reality we all must live with, and we all must learn from.

Politics and government have often been intertwined, that is nothing new: political concerns very often factor into major decisions at the highest levels of government. Presidents weighed political consequences in deciding when to enter World War II, when to leave Vietnam, and today how to support Ukraine and Israel.

However, it is also undeniable that political factors uncontrolled can be self-serving and destructive. The COVID crisis is an example of the danger posed when political factors outweigh the best interests of the American people.

From day one, the federal government under President Trump was driven by the political ramifications of the pandemic. Four years later, COVID is still being treated as a political football rather than an intelligent discussion to actually learn and improve from the historic crisis.

The most painful reality is that if another COVID type pandemic presented itself tomorrow, this nation would still be woefully unprepared. We still have not addressed the substantive public health issues presented during COVID because they are eclipsed by our hyper political environment.

This is especially worth contemplating as there is the possibility of a second Trump presidency and Trump recently said he handled COVID better than any other country. Really? The United States had more COVID cases and deaths than any other country: over 1.2 million Americans died.

With all the distracting topics consuming attention in this political year and this presidential election, I think it is safe to say that management of a pandemic should be at the top of the list.

As a matter of full disclosure, yes, I am a Democrat and was intimately involved as governor of New York. And yes, President Trump and I disagreed often all through the pandemic. However, facts are still facts even in this environment and time has revealed the truth.

Today, four years later, the results are clear and alarming.

I. The Great Deception: What Virus?

The White House and Republican establishment spent the early days of the pandemic trying to convince the public that COVID was not a serious problem. The assumption must have been, if you deny it, it won't happen.

On January 22, 2020, Trump proclaimed: **"**We have it totally under control.. it's going to be just fine."

Given the evidence of COVID's spread through China and Europe, Trump's pronouncements bordered on the delusional, saying on February 27, 2020, "It's going to disappear. One day, it's like a miracle, it will disappear." Less than a month later, he predicted the economy would be reopened by Easter and that "you'll have packed churches all over our country."

Trump elaborated his charade, effectively offering his own prescriptions ranging from hydroxychloroquine to sunlight, and even an "injection" of disinfectant as a deterrent. At one point, he tried to impede the states' ability to conduct COVID testing by pushing Congress to curtail funding based on his stated belief that "if we did very little testing, we wouldn't have the most cases!"

But Trump wasn't just wrong or ill advised, he knew full well the very real threat COVID presented as was detailed in memos written as early as January 29 by top White House advisor Peter Navarro predicting the loss of life could reach 2 million Americans. Indeed, Trump told Bob Woodward as early as February 7, "This is deadly stuff," two weeks later admitting he "liked playing it down."

"Playing it down" didn't work: denying reality seldom does.

During this once in a century pandemic not only did then-President Trump fail to lead, he fell under the weight of his own deception, obfuscation and incompetence. To date 1.2 million Americans have lost their lives to COVID, more than any country on the globe, and more than any war.

Had the administration not engaged in the "denial" strategy, medical personnel and operational preparations could have begun much sooner and the pandemic could have been better managed.

II. Denying Responsibility: Playing Politics: Abusing Government

Within months, the denial and diminishment effort was proven false. States were reporting exponentially higher increasing numbers. Even the White House couldn't deny reality any longer. They then pivoted to a strategy of avoiding substantive responsibility, creating a political narrative and abusing government authority to deceive the American people.

President Trump first pointed his finger to China declaring it was a "Chinese virus" and therefore any consequences would be directed to China. Trump also blamed the World Health Organization (WHO) and advanced the theory that the WHO purposely withheld information about the virus because they were controlled by China.

A) Denying Responsibility

Trump literally said "I don't take responsibility at all". Trump transferred vital responsibility to the nation's governors. Trump delegated more authority to 50 different governors than Lincoln delegated to General Grant.

Obviously, as a governor, I am a firm believer in states' rights. However, I am also a former cabinet secretary in the Clinton administration and understand the respective powers and authority of the federal and state governments. State governments have local hands-on control but the federal government has resources and authority.

There is no question that COVID was a national crisis. COVID did not stop at state borders, the federal government should have developed a uniform policy, rather than 50 states developing a patchwork policy quilt. Even neighboring states had different policies encouraging people to

cross borders for different services and spreading the virus at the same time. The variety of policies also demonstrated confusion and uncertainty and opened the door for politics and division, exasperating partisan differences and disunity, politicizing the pandemic.

Early on, the CDC insisted on controlling testing and prohibited state laboratories from participating, costing months of deadly delay. The CDC and CMS offered conflicting and incorrect information on basic issues, such as how the virus was transmitted. The president initiated a travel ban from China to the West Coast on Jan. 31, 2020 - minimizing the spread in that region, but left the East Coast wide open. Planes carrying COVID-infected passengers from Europe were allowed to land in the Northeast for weeks, until March 13 of that year.

States also struggled with operational responsibilities and were actually in competition with each other for scarce resources such as N 95 masks, testing capacity, vials, swabs, etc. States were literally in bidding wars, driving up the cost of essential items – it became the COVID hunger games.

The best structure would have been a federal / state partnership, each doing what they do best. However, Trump's political position was consistent: he had no responsibility. The virus was also consistent: it continued to spread.

B) The Political Blame Game

The Trump White House, rather than leading the national operation, abdicated responsibility. Rather than unifying the nation in a moment of crisis, they divided the country and fomented a civil war over COVID policy. They made it Democrats vs. Republicans, us vs. them, rather than – we united. On Feb 28th, 2020 Trump went so far as to proclaim that "Democrats are politicizing the coronavirus… this is their new hoax".

The political differences even extended to disputes within the Republican Party.

The political stage for election day, just months away, was being set: Democrats were cast as "big government" proponents, closing markets and controlling individual freedoms while Republicans believed in open markets, more independence and fewer government restrictions. In addition, and as usual, they claimed Democrats' government control policies were incompetent and counterproductive.

The nursing home controversy was the most despicable and destructive example of Republicans' politicization, deception and abuse of government during COVID. I have seen much ugliness and treachery in politics, but this was a new low. It was a complete fraud and a political smokescreen which did much damage and created misimpressions that continue today.

It was also a devastating and reckless diversion of medical resources at the most critical time.

Nursing homes were the places COVID did the most damage. They were where the tornado touched down, not just in New York but across the nation. Nursing homes were the locations of the greatest number of deaths and saddest human tragedies. By the end of 2020, the death rate for non-nursing home residents was 87 per 100,000 people. For nursing home residents it was 9200 per 100,000. That is a 108 times multiple. For Americans 65 and older, the death rate in nursing homes was 23 times greater than people 65 plus outside nursing homes. In at least 5 states – Rhode Island, Indiana, New Jersey, South Dakota and Connecticut, more than 12% of the nursing home population died from COVID between January and December 2020. **(See Exhibit J attached)**.

Nursing homes would be the focus of the COVID tragedy, that was clear early on, and the White House would need a foil: their story would be Democratic governors were in charge and they failed. All that was left to do was construct the narrative.

Attacking the Democratic governors was fundamentally disingenuous and fraudulent as the states did not create nursing home policy. States, for the most part, were merely following federal policy as dictated by CMS and the CDC.

On March 4, 9, 13 and 23, 2020, CDC and CMS issued clear guidelines on nursing home and hospital patients. **(See Exhibits A, B, C, D attached).** The CDC and CMS explicitly stated on March 9th and 13th:

"When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital? A nursing home can accept a resident diagnosed with COVID-19 and still under transmission based precautions for COVID-19 (meaning still infections) as long as the facility can follow CDC guidance for transmission-based precautions." The CDC and CMS published that on March 9th and 13th.

Over a dozen states implemented that federal guidance. The much criticized New York State Department of Health March 25 advisory, as well as several other DOH advisories issued that same month, were a compilation and reiteration of what the CMS and CDC had previously published on March 4, 9, 13 and 23. **(See Exhibits E, F, G, H).** If there were federal complaints to be had, they were against their own policy.

The Republicans either didn't know what their own federal agencies were doing or didn't care. Either is unacceptable.

The high point of the Republican political argument – or low point, depending on your point of view – was to accuse Democratic governors of acting not just incompetently, but illegally, in managing nursing homes.

In what was described as a "nakedly corrupt move," Trump went so far as to direct the DOJ to investigate four democratic – and only democratic – governors' management of nursing homes. **(See Exhibit I attached).** He called for the investigations the day before his speech to the Republican National convention.

Once again, New York and I were the prime targets, as reportedly, Trump was personally annoyed with me for criticizing him in my speech at the Democratic National Convention. Also reportedly, he was concerned that I might be part of the Democratic ticket.

There was no substantive reason to focus on New York's nursing homes as New York State had far fewer nursing home deaths pro rata than most states. Indeed, according to a study in the NIH library using CMS data, New York had the 12th LOWEST nursing home death rate of all 50 states by the end of 2020. **(See Exhibit J).** According to CDC data, New York's overall COVID death rate fell from the second highest in the country in 2020 to the 30th in 2021, when death rates in most red states went up - even after the vaccine had been introduced. It was just to distract from the Republican states' dismal performance and to focus the issue on Democrats.

Governor Whitmer (who was also being targeted by Trump) and I put out the following statement at the time:

"This is nothing more than a transparent politicalization of the Department of Justice in the middle of The Republican National Convention. They launch this nakedly partisan deflection. At least 14 states including Kentucky, Utah and Arizona, have issued similar nursing home

guidance – all based on federal guidelines and yet the four states listed in the DOJ's request have a Democratic governor."

Governor Whitmer and I continued in the statement, *"DOJ should send a letter to CMS and CDC since the states' advisories were modeled after their guidance."* **(See Exhibit K attached).**

This sentiment was also echoed by Minnesota Governor Tim Walz, who also followed the CDC and CMS guidance, when he said, *"This was federal guidance. This was what everyone was doing."*

I have no doubt that Trump's political operatives at the Department of Justice were looking to prosecute New York for anything they could find.

It is hard to miss the irony of Trump now spending days in courthouses, railing against the political weaponization of the Justice Department. Even if it is true, he is not one to complain.

The White House attack was diabolical but effective. He hurt Democrats and masked his own culpability for compounding COVID's loss of life.

This is not my opinion but proven documented history. The Republicans lied, distorted and misused the Justice Department to spin their tale. It is important to understand as a case study in government deception, and I encourage people to understand it, because the government abuse, especially the weaponization of the justice system, is a dangerous precedent and a true threat to democracy. **(See Exhibit L attached)**.

The underlying federal principles were clear: Making seniors remain in hospitals longer than necessary risked dangerous secondary infections and many of them required the specialized services of a nursing home. Also, hospital beds were scarce and needed to be utilized appropriately.

In New York, hospital discharge planners needed to confirm by telephone that the resident was medically stable for return and comprehensive discharge instructions needed to be provided by the hospital prior to transport to the nursing home. Further, admissions to nursing homes were subject to the nursing homes' acceptance. Nursing homes – by law – were required to have infection control plans in place tailored to individuals and were told to follow CDC infection prevention and control procedures.

To the extent that partisan critics claim there was confusion about nursing homes' legal obligation to be able to care for COVID residents before agreeing to admit them, the New York State Attorney General found "OAG's investigation to date has not revealed an admission from any nursing home operator that they could not care for referred residents." **(See Exhibit M attached)**.

The data is unequivocal: the patient readmission policies did not introduce COVID into nursing homes. In New York 304 of the 310 nursing homes – or 98% – of the nursing homes that accepted admissions from hospitals already had COVID in their facilities Some states that did not have the same admission policies had higher mortality rates than states that did. Many authorities, academic universities, and highly credible, independent, infectious disease experts have since determined that COVID entered nursing homes by asymptomatic staff members, unknowingly walking the virus in the front door from January to May before testing was widely available. **(See Exhibits N, O, P attached)**

Indeed, the New York State AG – no friend of mine – affirmatively verified the DOH guidance was consistent with the prior guidelines already in place and issued by the feds, unequivocally stating, "the March 25 guidance was consistent with the CMS guidance…It was also consistent with CDC Published Transmission-Based Precaution (T-BP) guidance, which was referred to in CMS's March 4 guidance..." **(See Exhibit M)**.

This conclusion was echoed in a June review by the Olson Group, an independent consulting firm retained by the Hochul administration – which also has no motivation to portray my administration in a favorable light. It found the state's COVID nursing home policies were "consistent with universal best practices in congregate care and accurately reflected the best understanding of the scientific community at the time they were issued".

III. The Results are in: The Country was Unprepared for COVID and Made Many Mistakes – Trump's Accusations Are Proven False

So four years later with facts and data, we know the truth and there are lessons that we can actually learn to improve our government's public health response, and that should be our focus.

A) The Nation was Unprepared

COVID had been in New York much earlier than anyone knew (as early as December 2019). It was the result of a federal health system that had little capacity to detect diseases entering the country and an inadequate international agency tracking transmissions.

While the President initially focused on cases in Washington State saying that the virus came from China and was carried on flights to the West Coast, that was the wrong focus. The virus had already traveled from China to Europe and then landed on flights in New York. The president looked west when he should have looked east.

Emergency medical supplies for the country were woefully inadequate. The federal government was to maintain regional stockpiles in case of a medical emergency, and they were not properly managed. This predated the Trump administration, as he rightfully pointed out.

Nor did this country have the capacity to manufacture emergency products quickly. Ironically, the states needed to buy N 95 masks from China. The nation's testing capacity was nowhere near the scale necessary to manage a national public health emergency. Likewise, the supply of trained emergency medical professionals was inadequate.

The medical knowledge on viral spread was unclear, inconsistent and slow in coming. It remains a topic of debate to this day. The WHO recently released a study changing their opinion on how COVID spreads, and by the way, there is disagreement with their new opinion also.

The nursing home deaths were not caused by the CMS, CDC or DOH policies. Research now shows that COVID was in the nursing homes as early as January and the infection rate in nursing homes tracked the infection rate in the surrounding geographic area – **Geographic areas in the states that had high COVID rates also had high COVID rates in nursing homes. Geographic areas that had lower COVID rates had lower COVID rates in the nursing homes,** meaning the virus most likely came in with the staff and visitors before anyone knew it was here and continued to be introduced into nursing homes by asymptomatic staff, who would leave every evening and return the next morning. **(See Exhibit J attached)**.

Remember we did not have adequate testing capacity to test the nursing home staff for several months, until early May 2020, which means well-meaning staff most likely brought the virus into the nursing homes with them from January through May.

While the State of New York was hit first and worst by COVID, once science provided guidance, we followed it. We were very aggressive in testing, vaccinations and social precautions and it worked. Where New York was a convenient political target, in reality, on the numbers New York was a much better performer than most states. **(See Exhibit Q attached).**

While New York was #2 in total deaths in 2020, by 2021 New York was #30.

All spin.

Journal Article

There is tremendous variation across states in the severity with which the pandemic struck nursing homes. Using the CMS data as of the last week of 2020, deaths per 1000 nursing home residents varied from a low of 12.8 in Alaska to a high of 134 in Rhode Island (see Appendix Fig. A3). In the 14 states with the highest death rates, more than 10 percent of the nursing home population died from COVID-19 in 2020.

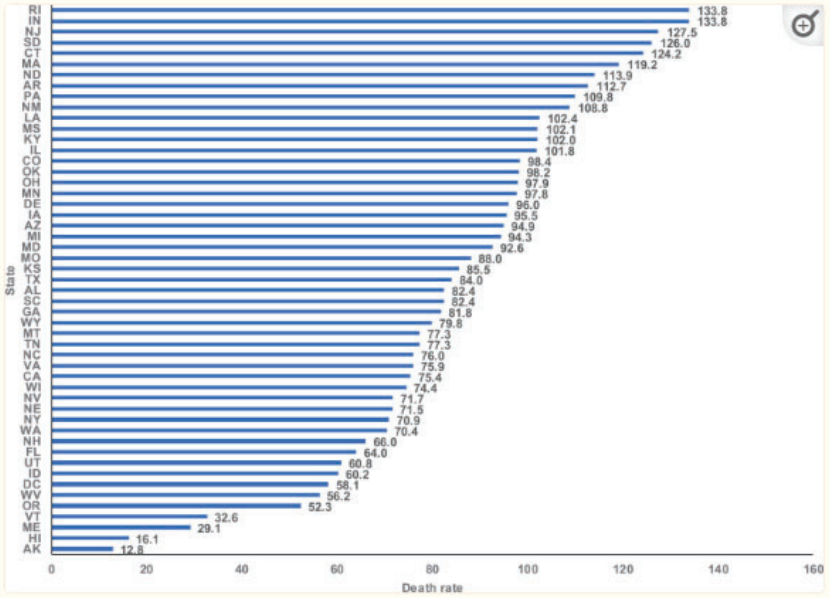


Fig. A3

COVID-19 Deaths Rates (deaths/1000) in Nursing Homes, as of End of 2020

Information taken from CMS COVID-19 surveillance data discussed in Section II.A.

Journal Article

(See Exhibit J)

B) Numerous Investigations Disprove Republican Allegations

What is the truth about Trump's nursing home accusations against New York and other Democratic states? They were all proven false by federal and state prosecutors and legislative committees. None of the nursing home allegations were proven true.

The Trump directed federal DOJ review (which was later closed as a result of no evidence of wrongdoing) triggered state and local investigations across the country. **(See Exhibit R attached)**.

Since then, the Department of Justice – three times –the Manhattan District Attorney, the AG, the state Assembly and an outside firm hired by the state of New York all investigated and not a single one validated the accusation of wrongdoing or that the March 25 guidance was a contributing factor, let alone the cause, of COVID being introduced into nursing homes. Undeterred, MAGA Republicans continued to repeat these falsehoods.

While Trump's accusations about mismanagement by the New York State Department of Health on nursing homes were proven wholly false, they nonetheless did much damage. Reputations were tarnished, good public servants who were killing themselves to help save lives were ruthlessly maligned, millions of taxpayer dollars wasted, and worst of all, families who lost loved ones in nursing homes suffered much torment and anguish for Trump's political tactics.

I remember when my father passed. The pain was incredible, and in many ways too much for me to handle, and I blamed doctors for not finding the problem earlier. In some ways, blaming the doctors made it easier because it took the emotion and turned it into anger and at least gave me an outlet. But the anger was unhealthy, it prolonged my pain and slowed my healing. Eventually I came to terms with the fact that there was really no one to blame. People did the best they could. I believe the same is true here.

Trump suggested that their lives could have been saved if government hadn't made mistakes, and that my friends, was just cruel.

IV. Republicans' Disregard for Science Led to Unnecessary Deaths

In 2020, when COVID first appeared, no one knew what hit us. The best scientific minds on the globe were confused. But in 2021 we had learned much about the disease, its spread and its prevention. The country made great progress in medical and scientific advances. We had a vaccine which was actually in part a credit to the hard work of the White House. Initially Trump touted the vaccine as one of his administration's "great accomplishments". Trump was right. Trump was for the vaccine before he was against it. The political division was not just Democrat versus Republican, but there were divisions within the Republican Party itself. Many Republican states, despite observing what happened in Europe, China and New York, ignored science and medical advice, instead opting for political propaganda, and saw infection rates explode and deaths follow.

Again politics drove public health policy even on something as basic as vaccines.Trump's primary opponent, Governor Desantis, was an ardent anti-vaxxer and Trump was feeling

backlash from conservatives so he pivoted and became an ardent opponent of vaccination policies.

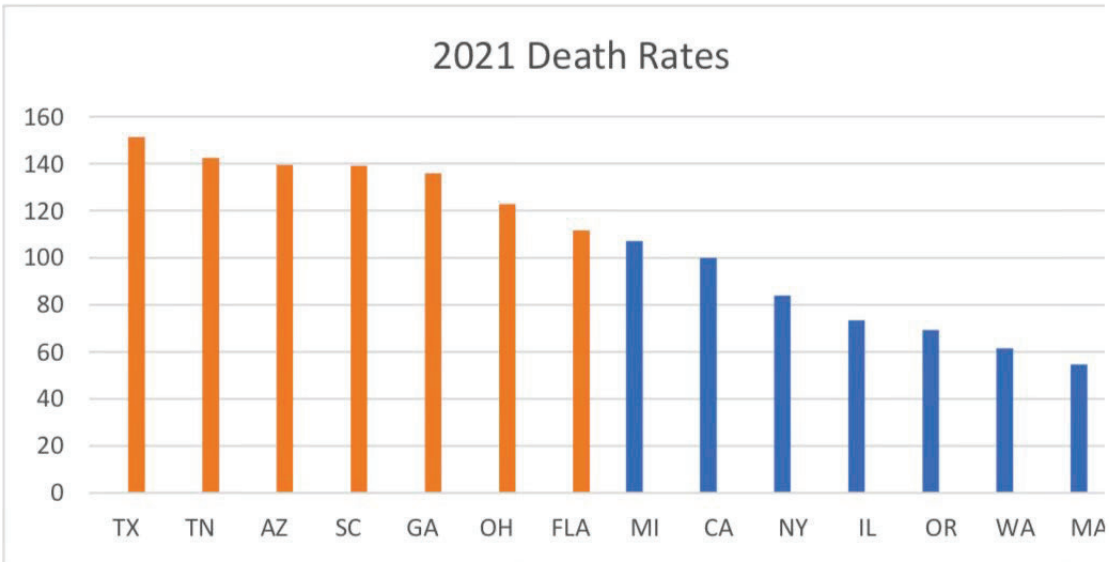
Trump's anti vax, science denier tactics were also adopted by the majority of the Republican establishment.

The results are clear.

The ultimate truth is found in the numbers.

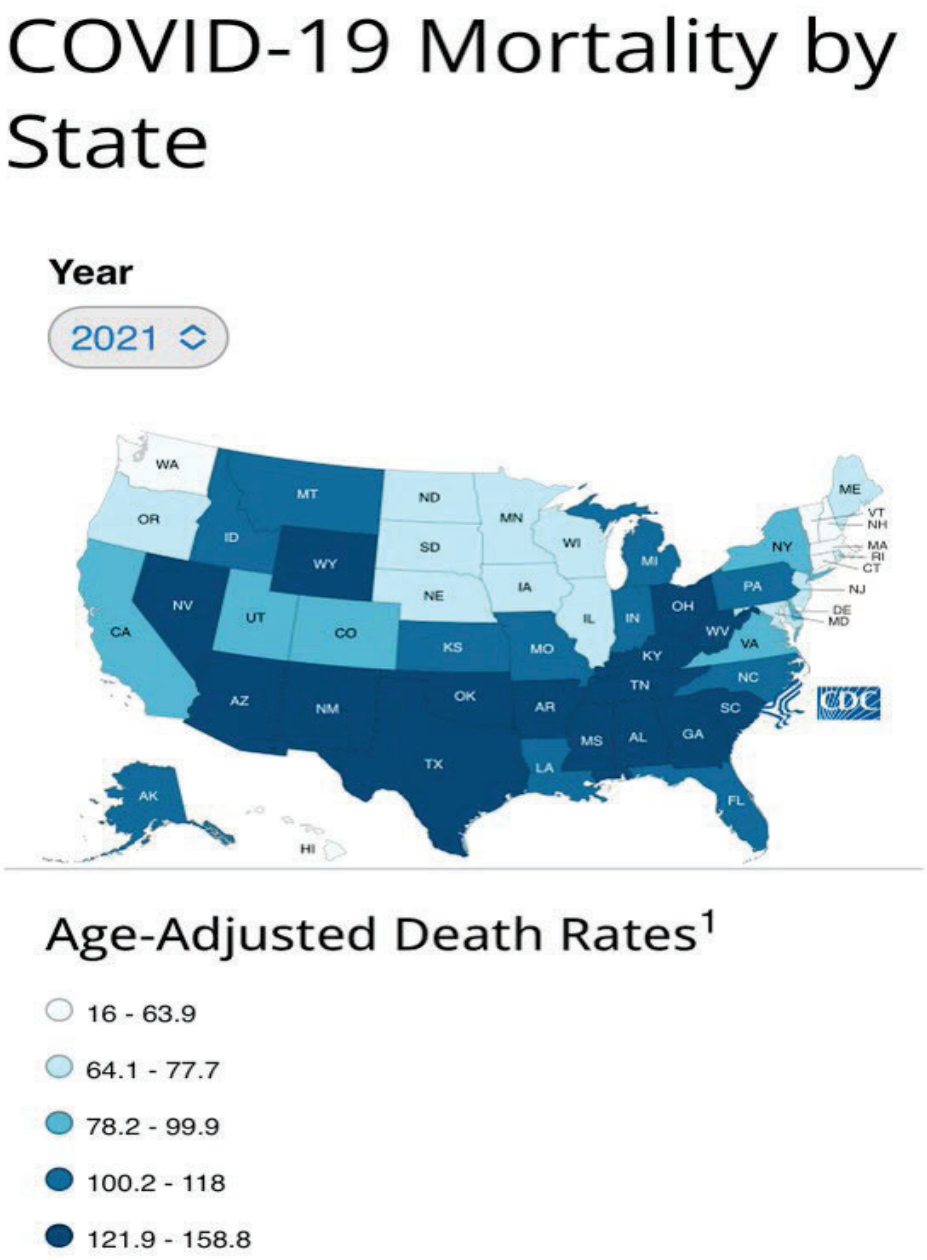
When one looks at the numbers across the country, once the vaccine was available, and we had the opportunity to save lives there's a gross disparity between those places, people, and political parties who accepted vaccines and precautions, and those who didn't.

Red states had more deaths proportionately than blue states. That is the irrefutable factual conclusion (Higher death rate states vs. lower death rate states were overwhelmingly red states vs. blue states)



COVID-19 Mortality by State; CDC, National Center for Human Statistics (2021)

https://www.cdc.gov/nchs/pressroom/sosmap/COVID19_mortality_final/COVID19.htm



COVID-19 Mortality by State; CDC, National Center for Human Statistics (2021)

https://www.cdc.gov/nchs/pressroom/sosmap/COVID19_mortality_final/COVID19.htm

ABC News said in March 2022, "Post-vaccine, death rates in red states were 38% higher than in blue states." Arielle Mitropoulos, *For Red and Blue America, A Glaring Divide In COVID-19 Death Rates Persist 2 Years Later*, ABC News (Mar. 28, 2022).

Yale researchers analyzed two representative states, Florida and Ohio, in a study that found "the excess death rate among Republican voters was 43% higher than the excess death rate among Democratic voters after vaccine eligibility was opened"; (Yale researchers, quoted by NPR)

https://www.npr.org/2023/07/25/1189939229/COVID-deaths-democrats-republicans-gap-study (https://www.npr.org/2023/07/25/1189939229/COVID-deaths-democrats-republicans-gap-study)

Pew Research found that during the third wave of the pandemic, which lasted from late 2020 into early 2021, the COVID death rate among the 20% of Americans who lived in the counties that voted for Trump at the highest rates was a whopping 170% than of those Americans who lived in the top Biden counties"

The highly credible federal National Institute of Health did the most comprehensive study, which was completed in 2023 and concluded the Republicans strategy of denial, diminishment and blame, allowed the virus to spread. The report said:

Red states had higher COVID-19 infection rates and deaths in 2021 compared to blue states.

The NIH report went on to say: "**Vaccination rates predicted fewer deaths in blue states**. This study shows an apparent association between mitigation efforts and lesser negative outcomes due to COVID-19. The individual role of citizens is not without consequence, but to ultimately lessen the aversive effects of COVID-19 and other viral threats in the United States, **it is necessary to behave collectively. Focusing on effectively implementing mitigation strategies across ideologies should be paramount** if communities are to address disease-based threats within."

It was all politics, all spin – a re-election strategy.

Ironically, in my opinion, the White House even did the politics wrong. If Trump had intelligently calculated the political consequences of COVID he could have assured his reelection.

COVID was a national crisis similar to 9/11: a moment Americans needed leadership and solidarity.

The political self-interest of Trump was actually NOT to act in his self-interest but to act in the nation's interest.

I believe if Trump had provided a modicum of responsible leadership rather than always looking for people to blame, if he was a force for unity rather than division, he would have been reelected.

Trump defeated Trump in the 2020 election.

Republicans learned an important lesson: play politics with the virus, the virus wins.

The old adage is true: the best politics is the best government.

That is the lesson that needs to be heeded here.

V. Aftermath Reflections

For myself, as a governor whose decisions during an historic crisis could literally make the difference between life and death, I spent many sleepless nights thinking about what I should do during those terrible times. I prayed on it, for the wisdom and the strength to lead the state through the darkest days.

I have spent many a night thinking about it since: what could I have done better at the time.

I rethink every decision and there are many things I would do differently if I knew then what I know now. Did we close down the State too late? Did we give the best guidance as soon as we had it? Could we have moved PPE, vaccines and life-saving equipment and personnel faster, better or more efficiently?

In retrospect even with all my press conferences and briefings, I could have communicated better about nursing homes. I believed at the time the accusations were all obviously political and not

even close to credible. Therefore I didn't aggressively fight to bat down the lies and myths. However, it allowed many families to believe the conspiracy theories about blunders in the nursing homes causing death for their loved ones which is a painful belief to carry. Especially since it wasn't true.

I wholeheartedly believed Trump was using the Department of Justice as a political weapon. Trump hired the campaign manager of my 2010 political opponent to be the US Health Department's chief spokesperson. He was a pure political operative for the conservative and Republican forces in New York.

He would work with Jeffrey Clark, the political operative of the Department of Justice, who is now indicted as part of the January 6 affair, and they were desperately seeking an indictment against Democratic governors – especially me – to exonerate Trump.

I am a lawyer and the former Attorney General of New York, and I know how the Justice system can be weaponized for purely political purposes.

I told my team to only release information that we had verified. I knew that if any information was proven false it would discredit the entire effort and trigger charges by the Department of Justice. Despite the hospitals, nursing homes and the Department of Health's best efforts, it took weeks to audit the data and the delay allowed conspiracy theories to circulate.

Another error in judgment I made is that I assumed the CDC and CMS and other federal health agencies were still doing their job and their guidance was official. I was wrong. Many top federal health officials have subsequently complained that they were politically influenced. The GAO has made that finding.

The challenge for nursing homes is to have staff that don't leave every day to go home, interact with other people, get infected, and return to the nursing home the next day. There was a potential model in Europe where the nursing home staff lived in the facility for the duration of COVID. In essence, it was a quarantine. The entire nursing home was a pod. I don't know if we could've found enough staff who would be willing to do it, but it would've been worth exploring. There may have been family members who would've volunteered or we may have been able to supplement medical personnel with national guard who could stay for a period of time. Anything we could do to avoid people coming and going would have been helpful. Obviously, there are challenges with this approach but there were better options worth trying. Once a test for a virus is manufactured to sufficient quantity, the problem is alleviated because

you can then test staff. The problem will be if any new virus appears, there will be a lag between the time a test is created and manufactured to the degree necessary to test tens of thousands of healthcare workers every day. That assumes another virus develops: God forbid!

There are many nights that I lie awake reliving the COVID nightmare.

New York was unique with possibly the highest infection rate on the globe. We literally didn't know what to do and neither did anyone else. We had the best minds on the globe advising us, and still, there was no answer. Society was near collapse. The ambulances couldn't keep up with the number of calls. The 911 lines were overwhelmed. The morgues were filled to the point that we needed to store bodies in refrigerated trucks. The shelves in food stores were virtually empty. Nurses and doctors were on the verge of collapse. Police, bus drivers, civil servants were asked to do impossible work for no extra pay, besides fulfilling a duty. And they did. Hospitals had collapsed, unable to manage the number of incoming patients. We were building emergency hospitals in parking lots which thankfully we didn't need because we slowed the infection rate. But we went to a place we had never been to before …. A very dark, frightening, lonely place. The essential goal was to slow the rate of infection, to avoid the collapse of the medical system and to save lives. And New Yorkers did. It required New Yorkers to change their behavior dramatically. And they did. Changing your life overnight is hard. Isolation is painful, but the state was New York tough, and in New York terms we would say our people "did the right thing", and I have no doubt but for the actions of New Yorkers, the situation would've been much much worse.

And we did not play any politics in New York. There were no Democratic lives and Republican lives, but only New Yorker's lives, and I would work with anyone who could help.

Today, with hindsight – it's so easy to tell people what they should've done.

For me, the question is what they did when it mattered, and that they did everything they could. They got up, they left their house, they left their family, and they entered the unknown. And I will not second-guess any of them. All I can say is thank you for doing the best you could. For those that now choose to criticize in hindsight, I ask them – where were they when it mattered? Where were the insights when the nation needed it?

Playing Monday morning quarterback is easy because you never lose a game. But that's not how life works.

One thing that brings me peace is knowing that me and my team worked as hard as we possibly could to save every single life we possibly could. We did it with the best information we had at the time, with the best possible intentions.

To all of those families who suffered the pain of losing a loved one throughout the course of this pandemic, I am sorry for every life lost and wish we could've done more. It was not for lack of trying, working or praying.

COVID was a tragedy that killed many and left many scarred.

My hope and prayer is that it never happens again and God forbid it does, I pray that we are better prepared than we were four years ago. I hope that this nation has a government it can trust and honor and have confidence that the government is providing the best advice science can offer. I hope we have a government we believe is acting in the best interest of the people and that we can be at a place where we put our differences aside and all work together as one - for the good of all. But that is the perpetual promise of America, literally our founding premise, E Pluribus Unum, Out of Many One. It is the only way we move forward.

Exhibit Index

Exhibit	Description
A.	Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement, and Hospital Discharge, Centers for Medicare & Medicaid Services (Mar. 4, 2020).
B.	Guidance For Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) In Nursing Homes ***(REVISED)***, Centers for Medicare & Medicaid Services (Mar. 9, 2020).
C.	Guidance For Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) In Nursing Homes ***(REVISED)***, Centers for Medicare & Medicaid Services (Mar. 13, 2020).
D.	Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance), Centers for Disease Control and Prevention (Mar. 23, 2020).
E.	Letter From Dr. Howard A. Zucker, New York State Department of Health (Feb. 6, 2020), and CDC documents cited in said letter.
F.	DAL NH 20-04 COVID Guidance for Nursing Homes-REVISED, New York State Department of Health (Mar. 11, 2020), and CDC documents cited in said guidance.
G.	Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities, New York State Department of Health (Mar. 13, 2020), and CDC documents cited in said advisory.
H.	Health Advisory: Respiratory Illness in Nursing Homes and Adult Care Facilities in Areas of Sustained Community Transmission of COVID-19, New York State Department of Health (Mar. 21, 2020).
I.	Press Release, Department of Justice Requesting Data From Governors of States that Issued COVID-19 Orders that May Have Resulted in Deaths of Elderly Nursing Home Residents, Department of Justice (Aug. 26, 2020), and letters sent to Governors Cuomo, Whitmer, Murphy and Wolf.
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M.	*Nursing Home Response to COVID-19 Pandemic*, New York State Office of the Attorney General Letitia James (Revised January 30, 2021).
N.	Paul Francis, *Debunking The Empire Center Analysis Attributing Nursing Home COVID-19 Deaths to DOH Policy*, Empire Report (Sep. 8, 2024).
O.	John Bacheller, *Was Cuomo's COVID Mandate Associated With Nursing Home Deaths? A Correction,* Policy By Numbers (Jul. 22, 2022).
P.	Paul Francis, *Re-Examining The Cuomo Administration's Nursing Home Policies During COVID-19*, Step Two Policy Project (Sep. 5, 2024).

Q.	*Factors Associated With Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis*, New York State Department of Health (Revised Feb. 11, 2021).
R.	Letter from Deputy Assistant Attorney General Joe Gaeta to Rep. Elise Stefanik, U.S. Department of Justice (Jul. 23, 2021).

Exhibit A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-13-Hospitals

DATE: **March 4, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- ***Coordination with the Centers for Disease Control (CDC) and local public health departments*** - We encourage all hospitals to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).
- ***Hospital Guidance and Actions*** **-** CMS regulations and guidance support hospitals taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, discharge and transfers from the hospital, and visitation.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients and residents of healthcare facilities from the spread of infectious disease. This memorandum responds to questions we have received and provides important guidance for hospitals and critical access hospitals (CAH's) in addressing the COVID-19 outbreak and minimizing transmission to other individuals. Specifically, we address FAQs related to optimizing patient placement, with the goal of addressing the needs of the individual patient while protecting other patients and healthcare workers.

Guidance

Hospitals should monitor the CDC website (https://www.cdc.gov/coronavirus/2019-ncov/index.html) for up to date information and resources. They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Hospitals should have plans for monitoring healthcare personnel with exposure to patients with known or suspected COVID-19. Additional information about monitoring healthcare personnel

is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Guidance for Addressing Patient Triage and Placement of Patients with known or suspected COVID-19

Which patients are at risk for severe disease for COVID-19?
Based upon CDC data, older adults and those with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes. This should be considered in the decision to monitor the patient as an outpatient or inpatient.

How should facilities screen visitors and patients for COVID-19?

Hospitals should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility. They should ask patients about the following:

1. Fever or symptoms of a respiratory infection, such as a cough and sore throat.
2. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
3. Contact with someone with known or suspected COVID-19.

For patients, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the patient in an examination room with the door closed. If the patient cannot be immediately moved to an examination room, ensure they are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website.

Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances, waiting rooms, patient check-ins, etc.

How should facilities monitor or restrict health care facility staff?
The same screening performed for visitors should be performed for hospital staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

    - Immediately stop work, put on a facemask, and self-isolate at home;
    - Inform the hospital's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

Hospitals should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

What are recommended infection prevention and control practices, including considerations for patient placement, when evaluating and care for a patients with known or suspected COVID-19?

Recommendations for patient placement and other detailed infection prevention and control recommendations regarding hand hygiene, Transmission-Based Precautions, environmental cleaning and disinfection, managing visitors, and monitoring and managing healthcare personnel are available in the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons under Investigation for COVID-19 in Healthcare Settings.

Do all patients with known or suspected COVID-19 infection require hospitalization?
Patients may not require hospitalization and can be managed at home if they are able to comply with monitoring requests. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

Are there specific considerations for patients requiring diagnostic or therapeutic interventions?
Patients with known or suspected COVID-19 should continue to receive the intervention appropriate for the severity of their illness and overall clinical condition. Because some procedures create high risks for transmission (e.g., intubation) additional precautions include: 1) HCP should wear all recommended PPE, 2) the number of HCP present should be limited to essential personnel, and 3) the room should be cleaned and disinfected in accordance with environmental infection control guidelines.

Additional information about performing aerosol-generating procedures is available here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

When is it safe to discontinue Transmission-based Precautions for hospitalized patients with COVID-19?
The decision to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens

More detailed information about criteria to discontinue Transmission-Based Precautions are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

Can hospitals restrict visitation of patients?
Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

What are the considerations for discharge to a subsequent care location for patients with COVID-19?
The decision to discharge a patient from the hospital should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient's ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

What are the implications of the Medicare Hospital Discharge Planning Regulations for Patients with COVID-19?
Medicare's Discharge Planning Regulations (which were updated in November 2019) requires that hospital assess the patient's needs for post-hospital services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.

concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

Important CDC Resources:

- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID19) or Persons Under Investigation for COVID-19 in Healthcare Settings.: **https://www.cdc.gov/coronavirus/2019-ncov/infection-control/controrecommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html**

CDC Updates:
https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

CMS Resources
CMS has additional guidance which may be beneficial to hospitals related to EMTALA requirements and other topics surrounding the health and safety standards during emergencies. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

Contact: Questions about this memorandum should be addressed to QSOG_EmergencyPrep@cms.hhs.gov. Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

Exhibit B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-14-NH
Expired 3/28/2023

DATE: **March 9, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes ***(REVISED)***

Effective 3/28/2023, the guidance in this memo is no longer in effect. For current guidance, see:

- ***QSO-20-39-NH Revised 09/23/2022 (Nursing Home Visitation);***
- ***CMS' Current Emergencies webpage***
- ***CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic webpage***

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Guidance for Infection Control and Prevention of COVID-19 -** 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*.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments -** We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).
- *Following the Food and Drug Administration's (FDA) emergency use authorization (EUA) expanding the use of certain industrial respirators to health care personnel, CMS is clarifying that such use is appropriate in Medicare/Medicaid certified providers and suppliers.*

Background

CMS is responsible for ensuring the health and safety of nursing home residents by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we are providing additional guidance to nursing homes to help control and prevent the spread of the virus.

Guidance

Facility staff should regularly monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, 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. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with residents, resident representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we're providing the following information (Frequently Asked Questions) about some specific areas related to COVID-19:

Guidance for Limiting the Transmission of COVID-19 for Nursing Homes

How should facilities monitor or *restrict* visitors?

If visitors meet the criteria below, facilities may restrict their entry to the facility. Regulations and guidance related to restricting a resident's right to visitors can be found at 42 CFR §483.10(f)(4), and at F-tag 563 of Appendix PP of the State Operations Manual. Specifically, a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons. This includes, "restrictions placed to prevent community-associated infection or communicable disease transmission to the resident. A resident's risk factors for infection (e.g., chronic medical conditions) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious."

Facilities should *actively* screen *and restrict* visitation *by those who meet the following criteria*:

1. Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat.
2. *In the last 14 days*, has had contact with someone *with a confirmed diagnosis of COVID-19*, or under investigation for COVID-19, *or are ill with respiratory illness.*
3. International travel within the last 14 days to countries *with sustained community transmission*. For updated information on *affected* countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
4. *Residing in a community where community-based spread of COVID-19 is occurring.*

For those individuals that do not meet the above criteria, facilities can allow entry but may require visitors to use Personal Protective Equipment (PPE) such as facemasks (see expanded guidance below).

Limiting visitors and individuals: Expanded recommendations:

CMS is providing the following expanded guidance to prevent the spread of COVID-19 (in addition to the information above about restricting visitors).

- ***Restricting** means the individual should not be allowed in the facility at all, until they no longer meet the criteria above.*
- ***Limiting** means the individual should not be allowed to come into the facility, except for certain situations, such as end-of-life situations or when a visitor is essential for the resident's emotional well-being and care.*
- ***Discouraging** means that the facility allows normal visitation practices (except for those individuals meeting the restricted criteria), however the facility advises individuals to defer visitation until further notice (through signage, calls, etc.).*

1. *Limiting or Discouraging visitation:*
    a) ***Limiting:** For facilities that are in counties, or counties adjacent to other counties where a COVID-19 case has occurred, we recommend **limiting** visitation (except in certain situations as indicated above). For example, a daughter who visits her mother every Monday, would cease these visits, and limit her visits to only those situations when her mom has a significant issue. Also, during the visit, the daughter would limit her contact with her mother and only meet with her in her room or a place the facility has specifically dedicated for visits.*
    b) ***Discouraging:** For all other facilities (nationwide) not in those counties referenced above, we recommend **discouraging** visitation (except in certain situations). See below for methods to discourage visitation. Also see CDC guidance to "stay at home" https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html#stay-home.*
2. *Facilities should increase visible signage at entrances/exist, offer temperature checks, increase availability to hand sanitizer, offer PPE for individuals entering the facility (if supply allows). Also, provide instruction, before visitors enter the facility and residents' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident's room. Individuals with fevers, other symptoms of COVID-19, or unable to demonstrate proper use of infection control techniques should be restricted from entry. Signage should also include language to discourage visits, such as recommending visitors defer their visit for another time or for a certain situation as mentioned above.*
3. *In addition to the screening visitors for the criteria for restricting access (above), facilities should ask visitors if they took any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If so, facilities should suggest deferring their visit to a later date. If the visitor's entry is necessary, they should use PPE while onsite. If the facility does not have PPE, the facility should restrict the individual's visit, and ask them to come back at a later date (e.g., after a 14 days with no symptoms of COVID-19).*
4. *In cases when visitation is allowable, facilities should instruct visitors to limit their movement within the facility to the resident's room (e.g., reduce walking the halls, avoid going to dining room, etc.)*
5. *Facilities should review and revise how they interact with volunteers, vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), other practitioners (e.g., hospice workers, specialists, physical therapy, etc.), and take necessary actions to prevent any potential*

transmission. For example, do not have supply vendors transport supplies inside the facility.

6. *Have them dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions. For example, hospice workers can enter a facility when using PPE properly.*
7. *In lieu of visits (either through limiting or discouraging), facilities can consider:*
    a) *Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).*
    b) *Creating/increasing listserv communication to update families, such as advising to not visit.*
    c) *Assigning staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date.*
    d) *Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.*
8. *When visitation is necessary or allowable, facilities should make efforts to allow for safe visitation for residents and loved ones. For example:*
    a) *Suggest limiting physical contact with residents and others while in the facility. For example, practice social distances with no hand-shaking or hugging, and remaining six feet apart.*
    b) *If possible (e.g., pending design of building), creating dedicated visiting areas (e.g., "clean rooms") near the entrance to the facility where residents can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.*
    c) *Residents still have the right to access the Ombudsman program. If in-person access is allowable, use the guidance mentioned above. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or any other entity listed in 42 CFR § 483.10(f)(4)(i).*
9. *Visitor reporting:*
    a) *Advise exposed visitors (e.g., contact with COVID-19 resident prior to admission) to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and if ill to self-isolate at home and contact their healthcare provider.*
    b) *Advise visitors to report to the facility any signs and symptoms of COVID-19 or acute illness within 14 days after visiting the facility.*

How should facilities monitor or restrict health care facility staff?

The same screening performed for visitors should be performed for facility staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:
    - Immediately stop work, put on a facemask, and self-isolate at home;
    - Inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing).

- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?
Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19.

Please check the following link regularly for critical updates, such as updates to guidance for using PPE: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the resident does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the resident and isolate him/her in a room with the door closed.

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?
A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19. Information on the duration of infectivity is limited, and the interim guidance has been developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. ***Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no***

symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room).

Other considerations for facilities:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), *reinforce strong hand-hygiene practices,* tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, resident check-ins, etc.
    - Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.).

Will nursing homes be cited for not having the appropriate supplies?

CMS is aware of that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHR) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact the CMS Branch Office.

What other resources are available for facilities to help improve infection control and prevention?

CMS urges providers to take advantage of several resources that are available:

CDC Resources:

- Infection preventionist training: https://www.cdc.gov/longtermcare/index.html
- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- *Information on affected US locations: https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html*

FDA Resources:

- *Emergency Use Authorizations:* https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations

CMS Resources:

- Long term care facility – Infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf
- Infection control toolkit for bedside licensed nurses and nurse aides ("Head to Toe Infection Prevention (H2T) Toolkit"): https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment
- Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

Contact: Email DNH_TriageTeam@cms.hhs.gov

NOTE: The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

Exhibit C

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-14-NH

DATE: **March 13, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes ***(REVISED)***

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Guidance for Infection Control and Prevention of COVID-19 -** 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*.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments -** We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).

Background

The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring the health and safety of nursing home residents by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we are providing additional guidance to nursing homes to help control and prevent the spread of the virus.

Guidance

Facility staff should regularly monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, 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. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with residents, resident representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we're providing the following information about some specific areas related to COVID-19:

Guidance for Limiting the Transmission of COVID-19 for Nursing Homes

For ALL facilities nationwide:
*Facilities should **restrict** visitation of **all** visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only. Facilities are expected to notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.). Note: If a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor's executive order, a facility would not be out of compliance with CMS' requirements. In this case, surveyors would still enter the facility, but not cite for noncompliance with visitation requirements.*

For individuals that enter in compassionate situations (e.g., end-of-life care), facilities should require visitors to perform hand hygiene and use Personal Protective Equipment (PPE), such as facemasks. Decisions about visitation during an end of life situation should be made on a case by case basis, which should include careful screening of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations). Those visitors that are permitted, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

Exceptions to restrictions:

- *Health care workers: Facilities should follow CDC guidelines for restricting access to health care workers found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html. This also applies to other health care workers, such as hospice workers, EMS personnel, or dialysis technicians, that provide care to residents. They should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers. Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).*
- *Surveyors: CMS and state survey agencies are constantly evaluating their surveyors to ensure they don't pose a transmission risk when entering a facility. For example, surveyors may have been in a facility with COVID-19 cases in the previous 14 days, but because they were wearing PPE effectively per CDC guidelines, they pose a low risk to*

transmission in the next facility, and must be allowed to enter. However, there are circumstances under which surveyors should still not enter, such as if they have a fever.

Additional guidance:

1. *Cancel communal dining and all group activities, such as internal and external group activities.*
2. *Implement active screening of residents and staff for fever and respiratory symptoms.*
3. *Remind residents to practice social distancing and perform frequent hand hygiene.*
4. *Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home.*
5. *For individuals allowed in the facility (e.g., in end-of-life situations), provide instruction, before visitors enter the facility and residents' rooms, provide instruction on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident's room. Individuals with fevers, other symptoms of COVID-19, or unable to demonstrate proper use of infection control techniques should be restricted from entry. Facilities should communicate through multiple means to inform individuals and non-essential health care personnel of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls.*
6. *Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19.*
7. *Facilities should review and revise how they interact vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery, etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility. Have them dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors if needed, as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions.*
8. *In lieu of visits, facilities should consider:*
    a) *Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).*
    b) *Creating/increasing listserv communication to update families, such as advising to not visit.*
    c) *Assigning staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date.*
    d) *Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.*
9. *When visitation is necessary or allowable (e.g., in end-of-life scenarios), facilities should make efforts to allow for safe visitation for residents and loved ones. For example:*
    a) *Suggest refraining from physical contact with residents and others while in the facility. For example, practice social distances with no hand-shaking or hugging, and remaining six feet apart.*
    b) *If possible (e.g., pending design of building), creating dedicated visiting areas (e.g., "clean rooms") near the entrance to the facility where residents can meet with*

visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.

c) *Residents still have the right to access the Ombudsman program. Their access should be restricted per the guidance above (except in compassionate care situations), however, facilities may review this on a case by case basis. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or any other entity listed in 42 CFR § 483.10(f)(4)(i).*

10. *Advise visitors, and any individuals who entered the facility (e.g., hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on findings.*

When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?

Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19.

Please check the following link regularly for critical updates, such as updates to guidance for using PPE: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the resident does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the resident and isolate him/her in a room with the door closed.

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?

A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19. Information on the duration of infectivity is limited, and the interim guidance has been

developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room).

Other considerations for facilities:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), *reinforce strong hand-hygiene practices,* tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, resident check-ins, etc.
    - Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.).

Will nursing homes be cited for not having the appropriate supplies?
CMS is aware of that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHR) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact the CMS Branch Office.

What other resources are available for facilities to help improve infection control and prevention?
CMS urges providers to take advantage of several resources that are available:

CDC Resources:

- Infection preventionist training: https://www.cdc.gov/longtermcare/index.html
- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- *Information on affected US locations: https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html*

CMS Resources:

- Guidance for use of Certain Industrial Respirators by Health Care Personnel: https://www.cms.gov/files/document/qso-20-17-all.pdf
- Long term care facility – Infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf
- Infection control toolkit for bedside licensed nurses and nurse aides ("Head to Toe Infection Prevention (H2T) Toolkit"): https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment
- Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

Contact: Email DNH_TriageTeam@cms.hhs.gov

NOTE: The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

Exhibit D

CDC Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

CDC guidance for COVID-19 may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Summary Page

Who this is for: Healthcare personnel managing patients with coronavirus disease 2019 (COVID-19).

What this is for: To help prevent the spread of the virus that causes COVID-19 in healthcare facilities.

How to use: Reference to guide healthcare regarding discontinuing transmission-based precautions and discharging hospitalized patients with COVID-19.

Summary of Recent Changes

Guidance as of March 23, 2020

- Clarified that patients with COVID-19 can be discharged from a healthcare facility whenever clinically indicated. Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.
- Updated guidance for a test-based strategy: The recommendation to collect both NP and OP swabs at each sampling has been changed so that only one swab, preferably an NP, is necessary at each sampling.
- Added guidance for:
  - Discontinuation of transmission-based precautions without testing.
  - Discontinuation of empiric transmission-based precautions for patients suspected of having COVID-19.
  - When using a testing-based strategy for discontinuation of transmission-based precautions is preferred.

This guidance is based on available information about COVID-19 and subject to change as additional information becomes available.

For discontinuation of home isolation for COVID-19, see (Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19).

For return-to-work criteria for healthcare personnel with COVID-19, see (Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19).

Discontinuation of transmission-based precautions for patients with COVID-19:

The decision to discontinue Transmission-Based Precautions should be made using a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy). Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.

1. *Test-based strategy.*
   - Resolution of fever without the use of fever-reducing medications **and**

- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens) [1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

2. *Non-test-based strategy*.
   - 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*

When a Testing-Based Strategy is Preferred

Hospitalized patients may have longer periods of SARS-CoV-2 RNA detection compared to patients with mild or moderate disease. Severely immunocompromised patients (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV) may also have longer periods of SARS-CoV-2 RNA detection and prolonged shedding of infectious recovery. These groups may be contagious for longer than others. In addition, placing a patient in a setting where they will have close contact with individuals at risk for severe disease warrants a conservative approach.

Hence, a test-based strategy is preferred for discontinuation of transmission-based precautions for patients who are

- Hospitalized or
- Severely immunocompromised or
- Being transferred to a long-term care or assisted living facility

If testing is not readily available, facilities should use the non-test-based strategy for discontinuation of Transmission-Based Precautions or extend the period of isolation beyond the non-test-based-strategy duration, on a case by case basis in consultation with local and state public health authorities.

Discontinuation of empiric transmission-based precautions for patients suspected of having COVID-19:

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of COVID-19 for a suspected COVID-19 patient can be made based upon having negative results from at least one FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2.

- If a higher level of clinical suspicion for COVID-19 exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2.
- If a patient suspected of having COVID-19 is never tested, the decision to discontinue Transmission-Based Precautions can be made based upon using the *non-test-based strategy* described above.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determines whether to continue or discontinue empiric Transmission-Based Precautions.

Disposition of Patients with COVID-19:

Patients can be discharged from the healthcare facility whenever clinically indicated.

If discharged to home:

- Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions. The decision to send the patient home should be made in consultation with the patient's clinical care

Precautions. The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and

patient's ability to adhere to home isolation recommendations. Guidance on implementing home care of persons who do not require hospitalization and the discontinuation of home isolation for persons with COVID-19 is available.

If discharged to a long-term care or assisted living facility, AND

- Transmission-Based Precautions *are still required*, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.
- Transmission-Based Precautions *have been discontinued,* but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room, and wear a facemask during care activities until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
- Transmission-Based Precautions *have been discontinued* and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

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Page last reviewed: March 23, 2020

Exhibit E

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 6, 2020

Dear Chief Executive Officer:

Thank you for your commitment and efforts to support New York State's (NYS) response to the 2019 Novel Coronavirus (2019-nCoV). All hospitals should be ready and equipped to promptly screen, and where appropriate, to isolate, further evaluate, and correctly manage patients presenting to their facility with the potential of being infected with 2019-nCoV, and to notify appropriate public health authorities of the patient's potential status.

In close coordination with the Centers for Disease Control and Prevention (CDC), the New York State Department of Health (Department) is providing updated information and guidance to facilities on this rapidly evolving situation, as it becomes available. It is important that all hospitals strictly adhere to the latest guidance from the Centers for Disease Control and Prevention (CDC) regarding personal protective equipment (PPE), available here: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html.

Shortages of PPE supplies may occur. The Department asks all facilities to compare their existing inventories of PPE, such as face shields, gowns, gloves, masks, N95 respirators, against the expected rate of use of these items under a surge situation, to determine the quantities needed to be on hand. Facilities or healthcare systems that identify a shortage of PPE, should use existing plans and vendor agreements to procure additional assets, by taking the following steps:

- Use existing vendor agreements and procurement plans to place orders for quantities needed by type and size of PPE.
- Activate existing Mutual Aid Agreements to obtain available support from those partners.
- Notify County Office of Emergency Management (OEM) when all existing agreements are exhausted and supply needs exceed those available from these sources.
- Coordinate with County OEM to identify and utilize other existing county resources.
- Notify the respective Department's Regional Office of ongoing need.
- If all local resources have been exhausted, submit a request, via your County OEM, to the NYS OEM. The request should include as much detail as available, but include at a minimum the following elements:

    - Type and Quantity of PPE by size
    - Point of Contact at the requesting facility or system
    - Delivery location
    - Date request is needed to be filled by
    - Record of pending orders

Upon receipt of a request submitted to NYS OEM, the Department will be notified and will use the information provided to validate the request and its ability to meet the identified need. Facilities should expect that the identified Point of Contact listed in the request will be

contacted by the Department for clarification and coordination. Please note that in order to assure adequate time to process and fill a request (as resources are available), a request should be submitted via your County OEM no later than 10 days before an item is out of stock at the requesting facility.

It is critical the healthcare facilities work in advance to prepare for anticipated shortages and to proactively work with all available sources of critical resources. It is also critical that healthcare facilities put controls in place to safeguard these resources and monitor their usage. The Department appreciates your attention to using the request process outlined above to help us all protect the health and safety of our residents.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner of Health

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

Key Concepts in This Guidance

- **Limit how germs can enter the facility.** Cancel elective procedures, use telemedicine when possible, limit points of entry and manage visitors, screen patients for respiratory symptoms, encourage patient respiratory hygiene using alternatives to facemasks (e.g., tissues to cover cough).
- **Isolate symptomatic patients as soon as possible.** Set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with door closed and private bathroom (as possible), prioritize AIIRs for patients undergoing aerosol-generating procedures.
- **Protect healthcare personnel.** Emphasize hand hygiene, install barriers to limit contact with patients at triage, cohort COVID-19 patients, limit the numbers of staff providing their care, prioritize respirators and AIIRs for aerosol-generating procedures, implement PPE optimization strategies to extend supplies.

Healthcare Personnel (HCP)

For the purposes of this document, HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including:

- body substances
- contaminated medical supplies, devices, and equipment
- contaminated environmental surfaces
- contaminated air

Background

This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), and gowns. Here is what is currently known:

This guidance is applicable to all U.S. healthcare settings. This guidance is not intended for non-healthcare settings (e.g., schools) OR for persons outside of healthcare settings. For recommendations regarding clinical management, air or ground medical transport, or laboratory settings, refer to the main CDC COVID-19 website.

Mode of transmission: Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within

close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely.

Shortage of personal protective equipment: Controlling exposures to occupational infections is a fundamental method of protecting HCP. Traditionally, a hierarchy of controls has been used as a means of determining how to implement feasible and effective control solutions. The hierarchy ranks controls according to their reliability and effectiveness and includes such controls as engineering controls, administrative controls, and ends with personal protective equipment (PPE). PPE is the least effective control because it involves a high level of worker involvement and is highly dependent on proper fit and correct, consistent use.

Major distributors in the United States have reported shortages of PPE, specifically N95 respirators, facemasks, and gowns. Healthcare facilities are responsible for protecting their HCP from exposure to pathogens, including by providing appropriate PPE.

In times of shortages, alternatives to N95s should be considered, including other classes of FFRs, elastomeric half-mask and full facepiece air purifying respirators, and powered air purifying respirators (PAPRs) where feasible. Special care should be taken to ensure that respirators are reserved for situations where respiratory protection is most important, such as performance of aerosol-generating procedures on suspected or confirmed COVID-19 patients or provision of care to patients with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis, measles, varicella).

The anticipated timeline for return to routine levels of PPE is not yet known. Information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are in limited supply and a companion checklist to help healthcare facilities prioritize the implementation of the strategies, is available.

Capacity across the healthcare continuum: Use of N95 or higher-level respirators are recommended for HCP who have been medically cleared, trained, and fit-tested, in the context of a facility's respiratory protection program . The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not have respiratory protection programs nor have they fit-tested HCP, hampering implementation of recommendations in the previous version of this guidance. This can lead to unnecessary transfer of patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care. In areas with community transmission, acute care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.

Many of the recommendations described in this guidance (e.g., triage procedures, source control) should already be part of an infection control program designed to prevent transmission of seasonal respiratory infections. As it will be challenging to distinguish COVID-19 from other respiratory infections, interventions will need to be applied broadly and not limited to patients with confirmed COVID-19.

This guidance is applicable to all U.S. healthcare settings. **This guidance is not intended for non-healthcare settings (e.g., schools) OR for persons outside of healthcare settings.** For recommendations regarding clinical management, air or ground medical transport, or laboratory settings, refer to the main CDC COVID-19 website.

Definition of Healthcare Personnel (HCP) –For the purposes of this document, HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Recommendations

1. Minimize Chance for Exposures

Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including SARS-CoV-2, the virus that causes COVID-19. Measures should be implemented before patient arrival, upon arrival, throughout the duration of the patient's visit, and until the patient's room is cleaned and disinfected. It is particularly important to protect individuals at increased risk for adverse outcomes from COVID-19 (e.g. older individuals with comorbid conditions), including HCP who are in a recognized risk category.

- Before Arrival
  - When scheduling appointments for routine medical care (e.g., annual physical, elective surgery), instruct patients to call ahead and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (e.g., cough, sore throat, fever[1]) on the day they are scheduled to be seen.
  - When scheduling appointments for patients requesting evaluation for a respiratory infection, use nurse-directed triage protocols to determine if an appointment is necessary or if the patient can be managed from home.
    - If the patient must come in for an appointment, instruct them to call beforehand to inform triage personnel that they have symptoms of a respiratory infection (e.g., cough, sore throat, fever[1]) and to take appropriate preventive actions (e.g., follow triage procedures, wear a facemask upon entry and throughout their visit or, if a facemask cannot be tolerated, use a tissue to contain respiratory secretions).
  - If a patient is arriving via transport by emergency medical services (EMS), EMS personnel should contact the receiving emergency department (ED) or healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.
- Upon Arrival and During the Visit
  - Consider limiting points of entry to the facility.
  - Take steps to ensure all persons with symptoms of COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette (see appendix), hand hygiene, and triage procedures throughout the duration of the visit.
    - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
    - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
    - Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
    - Consider establishing triage stations outside the facility to screen patients before they enter.
  - Ensure rapid safe triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough).
    - Prioritize triage of patients with respiratory symptoms.
    - Triage personnel should have a supply of facemasks and tissues for patients with symptoms of respiratory infection. These should be provided to patients with symptoms of respiratory infection at check-in. Source control (putting a facemask over the mouth and nose of a symptomatic patient) can help to prevent transmission to others.
    - Ensure that, at the time of patient check-in, all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of COVID-19 or contact with possible COVID-19 patients.
    - Isolate the patient in an examination room with the door closed. If an examination room is not readily available ensure the patient is not allowed to wait among other patients seeking care.
      - Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies.
      - In some settings, patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.
  - Incorporate questions about new onset of respiratory symptoms into daily assessments of all admitted patients. Monitor for and evaluate all new fevers and respiratory illnesses among patients. Place any patient with unexplained fever or respiratory symptoms on appropriate Transmission-Based Precautions and evaluate.

Additional considerations during periods of community transmission:

- Explore alternatives to face-to-face triage and visits.
- Learn more about how healthcare facilities can Prepare for Community Transmission

- Designate an area at the facility (e.g., an ancillary building or temporary structure) or identify a location in the area to be a "respiratory virus evaluation center" where patients with fever or respiratory symptoms can seek evaluation and care.
- Cancel group healthcare activities (e.g., group therapy, recreational activities).
- Postpone elective procedures, surgeries, and non-urgent outpatient visits.

2. Adhere to Standard and Transmission-Based Precautions

Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including COVID-19, are summarized below. Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE. This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all patient care; the full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

HCP (see Section 5 for measures for non-HCP visitors) who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or facemask, gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella). Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- Hand Hygiene
  - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
  - HCP should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
  - Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.
- Personal Protective Equipment
  Employers should select appropriate PPE and provide it to HCP in accordance with OSHA PPE standards (29 CFR 1910 Subpart I) . HCP must receive training on and demonstrate an understanding of:

- when to use PPE
- what PPE is necessary
- how to properly don, use, and doff PPE in a manner to prevent self-contamination
- how to properly dispose of or disinfect and maintain PPE
- the limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with known or suspected COVID-19 includes:

- Respirator or Facemask
  - Put on a respirator or facemask (if a respirator is not available) before entry into the patient room or care area.
  - N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure (See Section 4). See appendix for respirator definition. Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator or facemask. For guidance on extended use of respirators, refer to Strategies to Optimize the Current Supply of N95 Respirators
    - If reusable respirators (e.g., powered air purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
  - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Those that do not currently have a respiratory

protection program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program.

- Eye Protection
  - Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
  - Remove eye protection before leaving the patient room or care area.
  - Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.
- Gloves
  - Put on clean, non-sterile gloves upon entry into the patient room or care area.
    - Change gloves if they become torn or heavily contaminated.
  - Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.
- Gowns
  - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
  - If there are shortages of gowns, they should be prioritized for:
    - aerosol-generating procedures
    - care activities where splashes and sprays are anticipated
    - high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
      - dressing
      - bathing/showering
      - transferring
      - providing hygiene
      - changing linens
      - changing briefs or assisting with toileting
      - device care or use
      - wound care

3. Patient Placement

- For patients with COVID-19 or other respiratory infections, evaluate need for hospitalization. If hospitalization is not medically necessary, home care is preferable if the individual's situation allows.
- If admitted, place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.
  - Airborne Infection Isolation Rooms (AIIRs) (See definition of AIIR in appendix) should be reserved for patients who will be undergoing aerosol-generating procedures (See Aerosol-Generating Procedures Section)
- As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients. Dedicated means that HCP are assigned to care only for these patients during their shift.
  - Determine how staffing needs will be met as the number of patients with known or suspected COVID-19 increases and HCP become ill and are excluded from work.
  - It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should not be housed in the same room as a patient with an undiagnosed respiratory infection.
  - During times of limited access to respirators or facemasks, facilities could consider having HCP remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use). Risk of transmission from eye protection and facemasks during extended use is expected to be very low.

        - HCP must take care not to touch their eye protection and respirator or facemask .
        - Eye protection and the respirator or facemask should be removed, and hand hygiene performed if they become damaged or soiled and when leaving the unit.
    - HCP should strictly follow basic infection control practices between patients (e.g., hand hygiene, cleaning and disinfecting shared equipment).
- Limit transport and movement of the patient outside of the room to medically essential purposes.
    - Consider providing portable x-ray equipment in patient cohort areas to reduce the need for patient transport.
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Patients should wear a facemask to contain secretions during transport. If patients cannot tolerate a facemask or one is not available, they should use tissues to cover their mouth and nose.
- Personnel entering the room should use PPE as described above.
- Whenever possible, perform procedures/tests in the patient's room.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use (See Section 10).

4. Take Precautions When Performing Aerosol-Generating Procedures (AGPs)

- Some procedures performed on patient with known or suspected COVID-19 could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.
- If performed, the following should occur:
    - HCP in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.
    - AGPs should ideally take place in an AIIR.
    - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

5. Collection of Diagnostic Respiratory Specimens

- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 patient, the following should occur:
    - HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for specimen collection.
    - Specimen collection should be performed in a normal examination room with the door closed.
    - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

6. Manage Visitor Access and Movement Within the Facility

- Establish procedures for monitoring, managing and training all visitors, which should include:
    - All visitors should perform frequent hand hygiene and follow respiratory hygiene and cough etiquette precautions while in the facility, especially common areas.
    - Passively screen visitors for symptoms of acute respiratory illness before entering the healthcare facility
        - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) advising visitors not to enter the facility when ill.

- Informing visitors about appropriate PPE use according to current facility visitor policy
- Visitors to the most vulnerable patients (e.g., oncology and transplant wards) should be limited; visitors should be screened for symptoms prior to entry to the unit.

- Limit visitors to patients with known or suspected COVID-19. Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets. If visitation must occur, visits should be scheduled and controlled to allow for the following:
  - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.
  - Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
  - Visitors should not be present during AGPs or other specimen collection procedures.
  - Visitors should be instructed to only visit the patient room. They should not go to other locations in the facility.

Additional considerations during periods of community transmission:

- All visitors should be actively assessed for fever and respiratory symptoms upon entry to the facility. If fever or respiratory symptoms are present, visitor should not be allowed entry into the facility.
- Determine the threshold at which screening of persons entering the facility will be initiated and at what point screening will escalate from passive (e.g., signs at the entrance) to active (e.g., direct questioning) to restricting all visitors to the facility.
- If restriction of all visitors is implemented, facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care.
- Limit points of entry to the facility.

7. Implement Engineering Controls

- Design and install engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include:
  - physical barriers or partitions to guide patients through triage areas
  - curtains between patients in shared areas
  - air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained

8. Monitor and Manage Ill and Exposed Healthcare Personnel

- Facilities and organizations providing healthcare should implement sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance.
- Movement and monitoring decisions for HCP with exposure to COVID-19 should be made in consultation with public health authorities. Refer to the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) for additional information.

9. Train and Educate Healthcare Personnel

- Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

10. Implement Environmental Infection Control

- Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19.

- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.

- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
  - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Additional information about recommended practices for terminal cleaning of rooms and PPE to be worn by environmental services personnel is available in the Healthcare Infection Prevention and Control FAQs for COVID-19

11. Establish Reporting within and between Healthcare Facilities and to Public Health Authorities

- Implement mechanisms and policies that promote situational awareness for facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected COVID-19 patients and facility plans for response.
- Communicate and collaborate with public health authorities.
  - Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- Communicate information about known or suspected COVID-19 patients to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

12. Appendix: Additional Information about Airborne Infection Isolation Rooms, Respirators and Facemasks

Information about Airborne Infection Isolation Rooms (AIIRs):

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation).
- Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

Information about Respirators:

- A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.
- Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134). HCP should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
- NIOSH information about respirators
- OSHA Respiratory Protection eToo
- Strategies for Optimizing the Supply of N-95 Respirators

Filtering Facepiece Respirators (FFR) including N95 Respirators

- A commonly used respirator in healthcare settings is a filtering facepiece respirator (commonly referred to as an N95). FFRs are disposable half facepiece respirators that filter out particles.
- To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one. This is called “fit-testing” and is usually done in a workplace where respirators are used.
- Three key factors for an N95 respirator to be effective
- FFR users should also perform a user seal check to ensure proper fit each time an FFR is used.
- Learn more about how to perform a user seal check
- For more information on how to perform a user seal check: https://www.cdc.gov/niosh/docs/2018-130/pdfs/2018-130.pdf?id=10.26616/NIOSHPUB2018130

NIOSH-approved N95 respirators list.

- PAPRs have a battery-powered blower that pulls air through attached filters, canisters, or cartridges. They provide protection against gases, vapors, or particles, when equipped with the appropriate cartridge, canister, or filter.
- Loose-fitting PAPRs do not require fit testing and can be used with facial hair.
- A list of NIOSH-approved PAPRs is located on the NIOSH Certified Equipment List.

Information about Facemasks:

- If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces (often called source control).
- Facemasks are cleared by the U.S. Food and Drug Administration (FDA) for use as medical devices. Facemasks should be used once and then thrown away in the trash.

Important Links

- Respirator Trusted-Source Information
- Respirator Fact Sheet
- CDC’s Interim Guidance for Home Care not Requiring Hospitalization for COVID-19
- Strategies for Optimizing the Supply of PPE

Frequently Asked Questions: Healthcare Infection Prevention and Control

Summary of Changes to the Guidance:

Below are changes as of March 10, 2020.

- Updated PPE recommendations for the care of patients with known or suspected COVID-19:
  - Based on local and regional situational analysis of PPE supplies, facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to HCP.
    - Facemasks protect the wearer from splashes and sprays.
    - Respirators, which filter inspired air, offer respiratory protection.

    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Facilities that do not currently have a respiratory protection program, but care for patients infected with pathogens for which a respirator is recommended, should implement a respiratory protection program.
    - Eye protection, gown, and gloves continue to be recommended.
        - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP.
- Included are considerations for designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients and options for extended use of respirators, facemasks, and eye protection on such units. Updated recommendations regarding need for an airborne infection isolation room (AIIR).
    - Patients with known or suspected COVID-19 should be cared for in a single-person room with the door closed. Airborne Infection Isolation Rooms (AIIRs) (See definition of AIIR in appendix) should be reserved for patients undergoing aerosol-generating procedures (See Aerosol-Generating Procedures Section)
- Updated information in the background is based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), and gowns.
    - Increased emphasis on early identification and implementation of source control (i.e., putting a face mask on patients presenting with symptoms of respiratory infection).

Footnote

1. Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations.

Page last reviewed: March 19, 2020

Exhibit F

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 11, 2020

Re: DAL NH 20-04 COVID-19 Guidance for Nursing Homes - REVISED

Dear Owner/Operator & Nursing Home Administrator:

The New York State Department of Health (NYSDOH) is providing this guidance regarding precautions and procedures nursing homes must take to protect and maintain the health and safety of their residents and staff during the ongoing novel coronavirus (COVID-19) outbreak.

The nature of the spread of COVID-19 in the United States (US) is rapidly evolving. On Saturday, February 29, 2020, Washington state reported a healthcare worker and a resident at a Washington state nursing home both tested positive for COVID-19. Additional healthcare workers and residents at the facility have symptoms consistent with COVID-19. Evidence of community transmission in some areas has been recognized in multiple cases identified in the US.

Symptoms of the virus include fever, cough, shortness of breath, severe lower respiratory infection/acute respiratory distress syndrome and may also include nasal congestion, sore throat, diarrhea, and nausea. While some individuals ill with the virus may be asymptomatic or have mild illness, older individuals, particularly those with underlying health conditions, have shown greater susceptibility to the virus and often experience much more serious illness and outcomes. This potential for more serious illness among older adults, coupled with the more closed, communal nature of the nursing home environment, represents a risk of outbreak and a substantial challenge for nursing homes.

I. Stay Informed

It is expected that the spread of COVID-19 infections in the US will continue to increase. It is essential that all nursing home owner/operators, administrators, and clinical staff maintain situational awareness about the disease, its signs and symptoms, where cases and outbreaks are occurring, and necessary infection prevention and control procedures by regularly visiting the Centers for Disease Control and Prevention (CDC) and NYSDOH websites, as well as the NYSDOH Health Commerce System (HCS), to review the most up-to-date information for healthcare providers.

Because NYSDOH distributes alerts and advisories through the HCS notification system, it is essential that nursing homes maintain up-to-date contact information in the HCS

Communications Directory for their administrative and clinical leadership to be assured of receiving this information. The following are links to up-to-date information:

- CDC: https://www.cdc.gov/coronavirus/2019-ncov/index.html and https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
- NYSDOH: https://www.health.ny.gov/diseases/communicable/coronavirus.htm
- HCS: https://commerce.health.state.ny.us

II. Prevent Exposure to and Spread of Illness at the Nursing Home

Visitors to the nursing home may introduce COVID-19 infection into the nursing home if they are ill as a result of community transmission either internationally or in the US, or have had close contact (within 6 feet) to person(s) known to have or reasonably suspected of having COVID-19. The nursing home must have staff available to screen visitors for symptoms or potential exposure to someone with COVID-19. The nursing home should consider temporarily modifying visiting hours or procedures in order to facilitate monitoring in a situation of community transmission.

Nursing homes must post signage addressing visitation restrictions at all public entrances to the nursing home, as well as in foyers and vestibules leading into the facility and on the nursing home's website. The English version of the signage is attached to this letter and downloadable files with other language translations will be made available when ready on the NYSDOH public website COVID-19 page for healthcare providers at: https://www.health.ny.gov/diseases/communicable/coronavirus/providers.htm. In accordance with federal regulations (42 CFR § 483.10[f][4][iii]), state regulations (10 NYCRR § 415.19[b]) and Centers for Medicare and Medicaid Services (CMS) guidance, this signage advises that visitors with symptoms of illness such as fever, lower respiratory infection, shortness of breath, cough, nasal congestion, runny nose, sore throat, nausea, vomiting, and/or diarrhea are restricted from visiting the nursing home until symptoms have fully resolved.

It is important to remember that, per 42 CFR § 483.10(f)(4)(vi), the nursing home, "must inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, . . . the reasons for the restriction or limitation, and to whom the restrictions apply…". The nursing home must proactively post information about the visitation restrictions on their website, and send a letter or email to the family of each resident, to inform them of the visitation policy.

Similarly, nursing home staff are exposed to the general community each day and may become infected with an acute respiratory illness (e.g. COVID-19, influenza, respiratory syncytial virus (RSV)) if community transmission of that illness is occurring. Staff must be screened for respiratory symptoms upon arriving at work. It is critical that nursing homes strictly enforce their illness and sick leave policies. Staff showing these types of symptoms must not be

permitted to remain at work and must not return to work until completely recovered. NYSDOH regional epidemiologists are available for consultation regarding work restrictions for ill healthcare employees.

Staff persons who have been potentially exposed to someone with confirmed COVID-19, or to someone who is a person under investigation (PUI) for COVID-19, will be placed under *precautionary quarantine* or mandatory *quarantine* by public health officials, based on the symptoms presented and/or level of risk for having contracted COVID-19.

Nursing homes should consult with the most current guidance from NYSDOH. At this time, if the staff person is *asymptomatic* but has had a potential exposure to COVID-19, they must be furloughed for a period of 14 days following the exposure and will be subject to a quarantine order, which may be voluntary or mandatory quarantine depending on the exposure risk. If the staff person is *symptomatic*, the furlough will last for at least 14 days following the date of onset of symptoms. The staff person will be subject to a mandatory quarantine or isolation order, depending on whether the staff person is suspected or known to have COVID-19.

If a staff person is found to be ill upon screening, the nursing home should send the person home and direct them to contact their primary care physician immediately. If the nursing home has reason to be concerned that the person may be infected with COVID-19, the nursing home must send the person home and contact the New York State Department of Health.

If nursing home staff are concerned that there may have been transmission of illness within the facility, the nursing home must consult with the NYSDOH to determine if a NORA report is necessary.

The state regulations that address infection control policies are located in 10 NYCRR 415.19. All nursing homes must review and reinforce their policies and procedures with all staff, residents, and visitors regarding infection prevention and control including:

- Standard, Droplet and Contact precautions (applicable for the care of all residents) with their staff. Guidance is available on the CDC website at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html. A convenient poster reviewing PPE donning/doffing procedures is available at: https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf

- Hand hygiene practices and respiratory hygiene/cough etiquette. Ensure that adequate supplies of hand hygiene materials (both alcohol-based hand sanitizers and soap, water, and disposable paper towels) are readily available.

Daily, frequent cleaning and disinfection of commonly touched environmental surfaces must be done with EPA-registered, hospital-grade disinfectant to decrease environmental contamination. Staff must be instructed on the need to follow all manufacturer's instructions for use, including proper dwell times for all cleaners and disinfectants.

***2.* Conserve PPE, particularly surgical or procedure masks and N-95 respirators**

Global supplies of some types of PPE, including surgical masks, have been impacted by the COVID-19 outbreak response, and deliveries are delayed. NYSDOH asks nursing home administrators to encourage those staff who have chosen to not be vaccinated against influenza, to reconsider being vaccinated as a means of conserving on the number of surgical masks used by the nursing home each day.

As influenza is currently prevalent in NYS, staff at nursing homes who are unvaccinated for influenza need to comply with the regulations under Section 2.59 of the New York State Sanitary Code (10 NYCRR § 2.59). The regulation requires all health care and residential facilities and agencies regulated pursuant to Article 28, 36, or 40 of the Public Health Law to ensure that all personnel, as defined in the regulation, not vaccinated against influenza for the current influenza season, wear a surgical or procedure mask while in areas where patients or residents are typically present.

As an alternative to vaccination, where possible, nursing homes could consider assigning those unvaccinated staff to administrative duties that do not require them to interact with residents. Reducing the number of staff that must meet this regulation will assist in conserving critical supplies of masks. Additionally, until a vaccination is available for SARS-CoV-2 (the virus that causes COVID-19), use of surgical masks and N-95s will be necessary under different circumstances. Conservation of these masks to the extent possible is warranted.

Nursing homes should also practice administrative controls on the availability of masks by centrally holding and allocating masks to staff as necessary. However, nursing homes must ensure that these controls do not discourage the use of masks when indicated for patient care. Signage should be posted for visitors who require a mask based on the transmission-based precautions of the resident they are visiting. Any potentially contagious resident whose visitors are not restricted from visitation, should don a surgical or procedure mask before receiving the visitor(s). Visitors should be reminded to maintain social distancing during the visit, and to perform hand hygiene, i.e. washing their hands and applying hand sanitizer, following the visit.

Where use of an N95 respirator or mask is necessitated by a required procedure, nursing homes can help to conserve these respirators by limiting the number of staff who will perform these procedures.

3. What to do if a Resident is suspected of having a COVID-19 infection

Residents suspected of infection with COVID-19 should be given a surgical or procedure mask (not an N95) to wear. The facility must immediately contact the New York State Department of Health. While awaiting the transfer, the resident must be isolated in a separate room with the door closed. In this context, nursing home staff attending the PUI until they are transferred should follow CDC guidelines (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html) for the selection, use, and disposal of PPE (including gloves, isolation gown, and a properly fit-tested N95 or higher filtering facepiece respirator) and should maintain social distancing of at least 6 feet from the person.

III. Contact information:

You may contact the NYSDOH Bureau of Healthcare Associated Infections at 518-474-1142 during business hours or the NYSDOH Public Health Duty Officer at 1-866-881-2809 evenings, weekends, and holidays.

Please direct any questions you may have to the toll-free call center at 888-364-3065 or to icp@health.ny.gov

We thank you for your efforts in implementing these measures to prepare and protect your residents, staff, and visitors as we continue to manage the ongoing COVID-19 outbreak

Sincerely,

Sheila McGarvey
Director
Division of Nursing Homes & ICF/IID Surveillance
Center for Health Care Provider Services and Oversight

Attachment: Visitation Restrictions Signage - English

CDC Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

A new respiratory disease – coronavirus disease 2019 (COVID-19) – is spreading globally and there have been instances of COVID-19 community spread in the United States. The general strategies CDC recommends to prevent the spread of COVID-19 in LTCF are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza.

Long-term care facilities concerned that a resident, visitor, or employee may be a COVID-2019 patient under investigation should contact their local or state health department immediately for consultation and guidance.

Prevent the introduction of respiratory germs INTO your facility

- Post signs at the entrance instructing visitors not to visit if they have symptoms of respiratory infection.
- Ensure sick leave policies allow employees to stay home if they have symptoms of respiratory infection.
- Assess residents symptoms of respiratory infection upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.

Symptoms of respiratory infection, including COVID-19:

- Fever
- Cough
- Shortness of breath

Prevent the spread of respiratory germs WITHIN your facility

- Keep residents and employees informed.
  - Describe what actions the facility is taking to protect them, including answering their questions and explaining what they can do to protect themselves and their fellow residents.
- Monitor residents and employees for fever or respiratory symptoms.
  - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
  - In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
  - Healthcare personnel should monitor their local and state public health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents with acute respiratory infection, facilities should also consult with public health authorities for additional guidance.
- Support hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees.
  - Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).

  - Put alcohol-based hand rub in every resident room (ideally both inside and outside of the room).
  - Make sure tissues are available and any sink is well-stocked with soap and paper towels for hand washing.
- Identify dedicated employees to care for COVID-19 patients and provide infection control training.
  - Guidance on implementing recommended infection prevention practices is available in CDC's free online course — The Nursing Home Infection Preventionist Training — which includes resources checklists for facilities and employees to use.
- Provide the right supplies to ensure easy and correct use of PPE.
  - Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.
  - Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident room.
  - Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.

Prevent the spread of respiratory germs BETWEEN facilities

- Notify facilities prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care.
- Report any possible COVID-19 illness in residents and employees to the local health department, including your state HAI/AR coordinator.

For the most up-to-date information, visit www.cdc.gov/covid19.

Page last reviewed: March 1, 2020

CDC Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings

Updated February 21, 2020

Frequently Asked Questions: Healthcare Infection Prevention and Control

Background

Infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. Prompt detection and effective triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. All healthcare facilities must ensure that their personnel are correctly trained and capable of implementing infection control procedures; individual healthcare personnel should ensure they understand and can adhere to infection control requirements.

This guidance is based on the currently limited information available about coronavirus disease 2019 related to disease severity, transmission efficiency, and shedding duration. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States. This guidance is applicable to all U.S. healthcare settings. **This guidance is not intended for non-healthcare settings (e.g., schools) OR to persons outside of healthcare settings.** For recommendations regarding clinical management, air or ground medical transport, or laboratory settings, refer to the main CDC COVID-19 website.

Definition of Healthcare Personnel (HCP) – For the purposes of this guidance, HCP refers to all persons, paid and unpaid, working in healthcare settings engaged in patient care activities, including: patient assessment for triage, entering examination rooms or patient rooms to provide care or clean and disinfect the environment, obtaining clinical specimens, handling soiled medical supplies or equipment, and coming in contact with potentially contaminated environmental surfaces.

Recommendations

1. Minimize Chance for Exposures

Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including SARS-CoV-2, the virus that causes COVID-19. Measures should be implemented before patient arrival, upon arrival, and throughout the duration of the affected patient's presence in the healthcare setting.

- **Before Arrival**
  - When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever1) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedures).

- If a patient is arriving via transport by emergency medical services (EMS), the driver should contact the receiving emergency department (ED) or healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.

- Upon Arrival and During the Visit
  - Take steps to ensure all persons with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit. Consider posting visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use facemasks (See definition of facemask in Appendix) or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
  - Ensure that patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.
  - Ensure rapid triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough):
    - Identify patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility.
      - Implement triage procedures to detect persons under investigation (PUI) for COVID-19 during or before patient triage or registration (e.g., at the time of patient check-in) and ensure that all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of SARS-CoV-2, the virus that causes COVID-19, or contact with possible COVID-19 patients.
    - Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the PUI for COVID-19 in an Airborne Infection Isolation Room (AIIR), if available. See recommendations for "Patient Placement" below. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website.
    - Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19.
  - Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.

2. Adherence to Standard, Contact, and Airborne Precautions, Including the Use of Eye Protection

Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including those caused by COVID-19, are summarized below. Attention should be paid to training on correct use, proper donning (putting on) and doffing (taking off), and disposal of any PPE. This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all patient care; the full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. All HCP (see section 3 for measures for non-HCP visitors) who enter the room of a patient with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the following:

- Patient Placement
  - Place a patient with known or suspected COVID-19 (i.e., PUI) in an AIIR that has been constructed and maintained in accordance with current guidelines.
    - AIIRs are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.

        - If an AIIR is not available, patients who require hospitalization should be transferred as soon as is feasible to a facility where an AIIR is available. If the patient does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the patient and isolate him/her in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Once in an AIIR, the patient's facemask may be removed. Limit transport and movement of the patient outside of the AIIR to medically-essential purposes. When not in an AIIR (e.g., during transport or if an AIIR is not available), patients should wear a facemask to contain secretions.
    - Personnel entering the room should use PPE, including respiratory protection, as described below.
    - Only essential personnel should enter the room. Implement staffing policies to minimize the number of HCP who enter the room.
        - Facilities should consider caring for these patients with dedicated HCP to minimize risk of transmission and exposure to other patients and other HCP.
    - Facilities should keep a log of all persons who care for or enter the rooms or care area of these patients.
    - Use dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs). If equipment will be used for more than one patient, clean and disinfect such equipment before use on another patient according to manufacturer's instructions.
    - HCP entering the room soon after a patient vacates the room should use respiratory protection. (See personal protective equipment section below) Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). We do not yet know how long COVID-19 remains infectious in the air. In the interim, it is reasonable to apply a similar time period before entering the room without respiratory protection as used for pathogens spread by the airborne route (e.g., measles, tuberculosis). In addition, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.
- Hand Hygiene
    - HCP should perform hand hygiene using ABHS before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS.
    - Healthcare facilities should ensure that hand hygiene supplies are readily available in every care location.
- Personal Protective Equipment

  Employers should select appropriate PPE and provide it to HCP in accordance with OSHA's PPE standards (29 CFR 1910 Subpart I) . HCP must receive training on and demonstrate an understanding of when to use PPE; what PPE is necessary; how to properly don, use, and doff PPE in a manner to prevent self-contamination; how to properly dispose of or disinfect and maintain PPE; and the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE:
    - Gloves
        - Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.
        - Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.
    - Gowns
        - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
    - Respiratory Protection
        - Use respiratory protection (i.e., a respirator) that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator before entry into the patient room or care area. See appendix for respirator definition.
        - Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator.

        - If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
        - Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard (29 CFR 1910.134). Staff should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
    - Eye Protection
        - Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.
- Use Caution When Performing Aerosol-Generating Procedures
    - Some procedures performed on COVID-19 patients could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.
    - If performed, these procedures should take place in an AIIR and personnel should use respiratory protection as described above. In addition:
        - Limit the number of HCP present during the procedure to only those essential for patient care and procedural support.
        - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.
- Diagnostic Respiratory Specimen Collection
    - Collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) are likely to induce coughing or sneezing. Individuals in the room during the procedure should, ideally, be limited to the patient and the healthcare provider obtaining the specimen.
    - HCP collecting specimens for testing for SARS-CoV-2, the virus that causes COVID-19, from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection.
    - These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
- Duration of Isolation Precautions for PUIs and confirmed COVID-19 patients
    - Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.
    - Factors that should be considered include: presence of symptoms related to COVID-19 infection, date symptoms resolved, other conditions that would require specific precautions (e.g., tuberculosis, *Clostridioides difficile),* other laboratory information reflecting clinical status, alternatives to inpatient isolation, such as the possibility of safe recovery at home.
    - For additional information refer to the Interim Considerations for Disposition of Hospitalized Patients with COVID-19.

3. Manage Visitor Access and Movement Within the Facility

- Establish procedures for monitoring, managing and training visitors.
- Restrict visitors from entering the room of known or suspected COVID-19 patients (i.e., PUI). Alternative mechanisms for patient and visitor interactions, such as video-call applications on cell phones or tablets should be explored. Facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care.
- Visitors to patients with known or suspected COVID-19 (i.e., PUI) should be scheduled and controlled to allow for:
    - Screening visitors for symptoms of acute respiratory illness before entering the healthcare facility.
    - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.

- Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
- Facilities should maintain a record (e.g., log book) of all visitors who enter patient rooms.
- Visitors should not be present during aerosol-generating procedures.
- Visitors should be instructed to limit their movement within the facility.
- Exposed visitors (e.g., contact with COVID-19 patient prior to admission) should be advised to report any signs and symptoms of acute illness to their health care provider for a period of at least 14 days after the last known exposure to the sick patient.

- All visitors should follow respiratory hygiene and cough etiquette precautions while in the common areas of the facility.

4. Implement Engineering Controls

- Consider designing and installing engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include physical barriers or partitions to guide patients through triage areas, curtains between patients in shared areas, closed suctioning systems for airway suctioning for intubated patients, as well as appropriate air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained.

5. Monitor and Manage Ill and Exposed Healthcare Personnel

- Movement and monitoring decisions for HCP with exposure to COVID-19 should be made in consultation with public health authorities. Refer to the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) for additional information.
- Facilities and organizations providing healthcare should implement sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance.

6. Train and Educate Healthcare Personnel

- Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- HCP must be medically cleared, trained, and fit tested for respiratory protection device use (e.g., N95 filtering facepiece respirators), or medically cleared and trained in the use of an alternative respiratory protection device (e.g., Powered Air-Purifying Respirator, PAPR) whenever respirators are required. OSHA has a number of respiratory training videos .
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

7. Implement Environmental Infection Control

- Dedicated medical equipment should be used for patient care.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. These products can be identified by the following claim:
  - "[Product name] has demonstrated effectiveness against viruses similar to COVID-19 on hard non-porous surfaces. Therefore, this product can be used against COVID-19 when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces."
  - This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, "1-800" consumer

information services, social media sites and company websites (non-label related). Specific claims for "COVID-19" will not appear on the product or master label.
    - See additional information about EPA-approved emerging viral pathogens claims .
    - If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Detailed information on environmental infection control in healthcare settings can be found in CDC's Guidelines for Environmental Infection Control in Health-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [section IV.F. Care of the environment].

8. Establish Reporting within Healthcare Facilities and to Public Health Authorities

- Implement mechanisms and policies that promptly alert key facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected COVID-19 patients (i.e., PUI).
- Communicate and collaborate with public health authorities.
    - Promptly notify state or local public health authorities of patients with known or suspected COVID-19 (i.e., PUI). Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.

Appendix: Additional Information about Respirators and Facemasks:

Information about Respirators:

- A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.
- Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134). HCP should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
- NIOSH information about respirators
- OSHA Respiratory Protection eTool

Filtering Facepiece Respirators (FFR) including N95 Respirators

- A commonly used respirator is a filtering facepiece respirator (commonly referred to as an N95). Filtering facepiece respirators are disposable half facepiece respirators that filter out particles.
- To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one (this is called "fit-testing" and is usually done in a workplace where respirators are used).
- Three key factors for an N95 respirator to be effective
- FFR users should also perform a user seal check to ensure proper fit each time an FFR is used.
- More information on how to perform a user seal check

See a list of NIOSH-approved N95 respirators

Powered Air-Purifying Respirators (PAPRs)

- Powered air-purifying respirators (PAPRs) have a battery-powered blower that pulls air through attached filters, canisters, or cartridges. They provide protection against gases, vapors, or particles, when equipped with the appropriate cartridge, canister, or filter.
- Loose-fitting PAPRs do not require fit testing and can be used with facial hair.

- A list of NIOSH-approved PAPRs is located on the NIOSH Certified Equipment List

Information about Facemasks:

- If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces (often called source control).
- Facemasks are cleared by the U.S. Food and Drug Administration (FDA) for use as medical devices. Facemasks should be used once and then thrown away in the trash.

Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19)

CDC has developed interim guidance for staff at local and state health departments, infection prevention and control professionals, healthcare providers, and healthcare workers who are coordinating the home care and isolation of people who are confirmed to have, or being evaluated for coronavirus disease 2019 (COVID-19) (see Criteria to Guide Evaluation of Persons Under Investigation (PUI) for COVID-19).

Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19)

Important Links and Additional Infection Control Resources

- World Health Organization (WHO) Coronavirus Disease 2019 (COVID-19) technical guidance
- Respirator Trusted-Source Information
- Respirator Fact Sheet

Footnote

1. Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations.

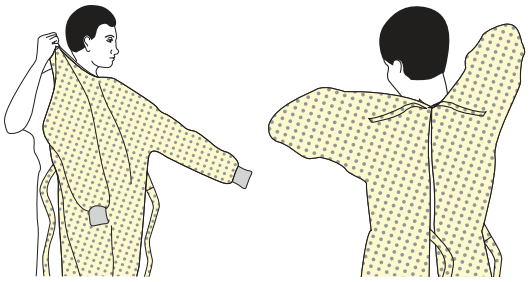
Page last reviewed: February 21, 2020

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

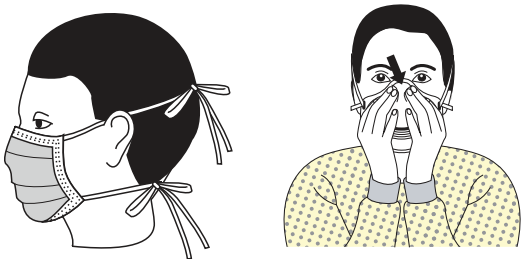
1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

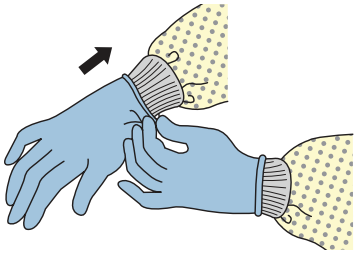


3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

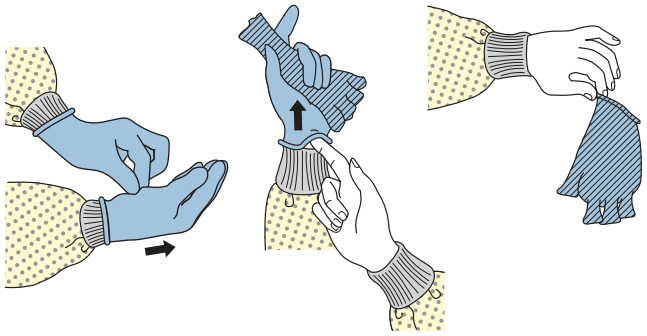
CS250672-E

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

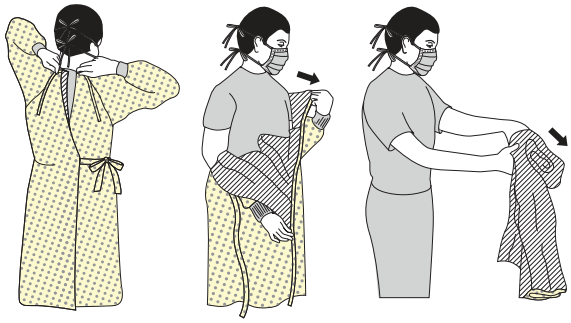


2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

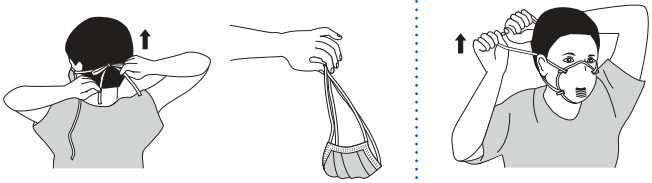
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

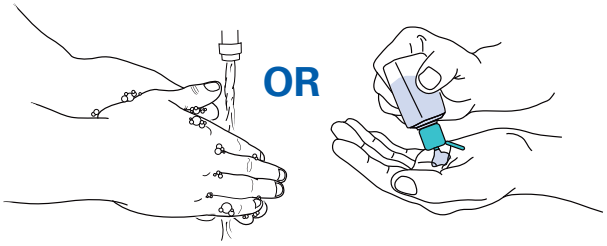


4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

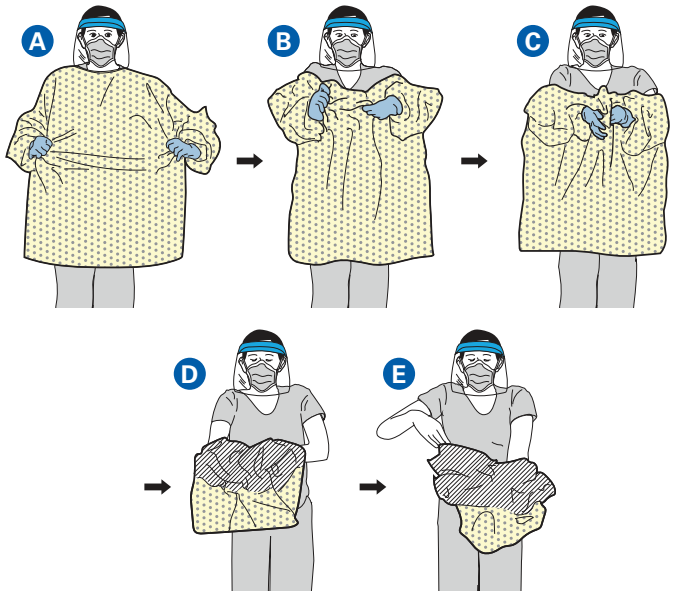
CS250672-E

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

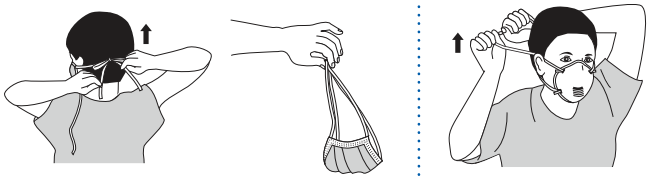


2. GOGGLES OR FACE SHIELD

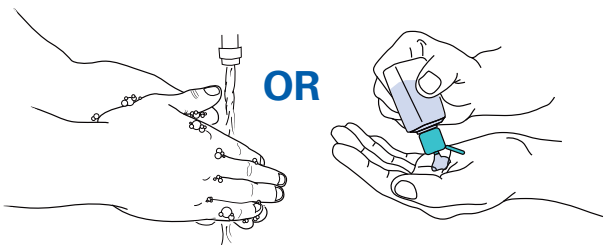
- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CS250672-E

Exhibit G

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

DATE: March 13, 2020

TO: Nursing Homes (NHs) and Adult Care Facilities (ACFs)

FROM: NYSDOH Bureau of Healthcare Associated Infections (BHAI)

Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities

Please distribute immediately to:
Administrators, Infection Preventionists, Medical Directors, Physicians, Physician Assistants, Nurse Practitioners, Nursing Staff, Risk Managers, and Public Affairs.

COVID-19 has been detected in multiple communities around New York State. Residents of NHs and ACFs are at especially high risk of severe morbidity and mortality. Healthcare personnel (HCP), other direct care providers and visitors who enter NHs and ACFs while symptomatic or asymptomatic with COVID-19 present a high risk for outbreaks. At this time NHs and ACFs statewide are required to take the following actions. This guidance supersedes previous NYSDOH guidance.

To prevent the introduction of COVID-19 into NHs and ACFs

1. Effective immediately, suspend 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.[1] The duration and number of visits should be minimized. Visitors should wear a facemask while in the facility and should be allowed only in the resident's room. Facilities must provide other methods to meet the social and emotional needs of residents, such as video calls. Facilities shall post signage notifying the public of the suspension of visitation and proactively notify resident family members.
2. Immediately implement health checks for all HCP and other facility staff at the beginning of each shift. This includes all personnel entering the facility regardless of whether they are providing direct patient care. Facility staff performing health checks must wear facemasks. HCP and other facility staff with symptoms or with T ≥ 100.0 F should be sent home, and HCP and other facility staff who develop symptoms or fever while in the facility should immediately go home.
3. All HCP and other facility staff shall wear 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.

If there are confirmed cases of COVID-19 in a NH or ACF

1. Notify the local health department and NYSDOH if not already involved.

[1] Any such visitors shall be checked as if they are staff.

2. In NHs, actively monitor all residents on affected units once per shift. This monitoring must include a symptom check, vitals, lung auscultation, and pulse oximetry.
3. Assure that all residents in affected units remain in their rooms. Cancel group activities and communal dining. Offer other activities for residents in their rooms to the extent possible, such as video calls.
4. Residents must wear facemasks when HCP or other direct care providers enter their rooms, unless such is not tolerable.
5. Do not float staff between units. Cohort residents with COVID-19 with dedicated HCP and other direct care providers. Minimize the number of HCP and other direct care providers entering rooms.
6. In NHs, all residents on affected units should be placed on droplet and contact precautions, regardless of the presence of symptoms and regardless of COVID-19 status. HCP and other direct care providers should wear gown, gloves, eye protection (goggles or a face shield), and N95 respirators (or equivalent) if the facility has a respiratory program with fit tested staff and N95s. Otherwise, HCP and other direct care providers should wear gown, gloves, eye protection, and facemasks. Facilities may implement extended use of eye protection and facemasks/N95s when moving from resident to resident (i.e. do not change between residents) unless other medical conditions which necessitate droplet precautions are present. However, gloves and gowns must be changed and hand hygiene must be performed.
7. For residents who initially test negative, re-testing should be performed immediately if they develop symptoms consistent with COVID-19.

If there are suspected cases of COVID-19 in a NH or ACF

Residents suspected of infection with COVID-19 should be given a facemask to wear, and the facility must immediately contact the NYSDOH. The resident must be isolated in a separate room with the door closed. Staff attending the resident if and until they are transferred should wear gowns, gloves, eye protection (goggles or a face shield), and facemasks and should maintain social distancing of at least six (6) feet from the resident except for brief, necessary interactions. Facilities should bundle care and minimize the number of HCP and other staff who enter rooms to reduce the number of personnel requiring facemasks.

For ACF Resident Access to the Community

In areas of high concentrations of positive coronavirus cases, residents should be encouraged to remain at home. If residents access the community and community transmission is recognized in the area where the ACF is located, the ACF must have staff available to screen residents for symptoms or potential exposure to someone with COVID-19.

Facilities should also refer to the following documents for more information:

- From CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
- From CMS: https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf
- From NYSDOH (on Health Commerce): https://apps.health.ny.gov/pub/ctrldocs/alrtview/postings/Nursing_Home_Guidance_3_1583593822992_0.6.20_with_signage.pdf

General questions or comments about this advisory can be sent to icp@health.ny.gov, covidadultcareinfo@health.ny.gov, and/or covidnursinghomeinfo@health.ny.gov.

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Preparing for COVID-19: Long-term Care Facilities, Nursing Homes

A new respiratory disease – coronavirus disease 2019 (COVID-19) – is spreading globally and there have been instances of COVID-19 community spread in the United States. The general strategies CDC recommends to prevent the spread of COVID-19 in LTCF are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza.

Symptoms of respiratory infection, including COVID-19:

- Fever
- Cough
- Shortness of breath

Long-term care facilities concerned that a resident, visitor, or employee may be a COVID-2019 patient under investigation should contact their local or state health department immediately for consultation and guidance.

COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings

Nursing homes and other long-term care facilities can take steps to assess and improve their preparedness for responding to coronavirus disease 2019 (COVID-19). This checklist should be used as one tool to develop a comprehensive COVID-19 response plan, including plans for:

- Rapid identification and management of ill residents
- Considerations for visitors
- Supplies and resources
- Sick leave policies and other occupational health considerations
- Education and training
- Surge capacity for staffing, equipment and supplies, and postmortem care

The checklist identifies key areas that long-term care facilities should consider in their COVID-19 planning. Long-term care facilities can use this tool to self-assess the strengths and weaknesses of current preparedness efforts. This checklist does not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19.

COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings [PDF – 1 MB]

Interim Additional Guidance for Infection Prevention and Control for

Patients with Suspected or Confirmed COVID-19 in Nursing Homes

Summary of Changes to the Guidance:

Updated guidance to recommend that nursing homes:

- Restrict all visitation except for end of life situations.
- Restrict all volunteers and non-essential healthcare personnel (HCP), including non-essential healthcare personnel (e.g., barbers)
- Cancel all group activities and communal dining
- Implement active screening of residents and HCP for fever and respiratory symptoms

COVID-19 is being increasingly reported in communities across the United States. It is likely that SARS-CoV-2 is circulating in all communities even if cases have not yet reported. As such, nursing homes should assume it is now in their community and move to restrict all visitors and unnecessary HCP from the facility. Cancel group activities and communal dining and implement active screening of residents and HCP for fever and respiratory symptoms.

Background

Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at the highest risk of being affected by COVID-19. If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness.

Visitor Restrictions
Ill visitors and healthcare personnel (HCP) are the most likely sources of introduction of COVID-19 into a facility. CDC recommends aggressive visitor restrictions and enforcing sick leave policies for ill HCP, even before COVID-19 is identified in a community or facility.

Use these recommendations with CDC's Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings. These recommendations are specific for nursing homes, including skilled nursing facilities. Much of this information could also be applied in assisted living facilities. This information complements, but does not replace, the general infection prevention and control recommendations for COVID-19.

This guidance is based on the currently available information about COVID-19. It will be refined and updated as more information becomes available and as response needs change in the United States. It is important to understand transmission dynamics in your community to inform strategies to prevent introduction or spread of COVID-19 in your facility. Consultation with public health authorities can help you better understand if transmission of COVID-19 is occurring in your community.

Things facilities should do now

Educate Residents, Healthcare Personnel, and Visitors

- Share the latest information about COVID-2019.
- Review CDC's Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings.
- Educate and train HCP.
  - Reinforce sick leave policies. Remind HCP not to report to work when ill.
  - Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE.

- Educate both facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers. Including consultants is important because they often provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.
- Educate residents and families including:
  - information about COVID-19
  - actions the facility is taking to protect them and their loved ones, including visitor restrictions
  - actions residents and families can take to protect themselves in the facility

Provide Supplies for Recommended Infection Prevention and Control Practices

- Hand hygiene supplies:
  - Put alcohol-based hand sanitizer with 60–95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory hygiene and cough etiquette:
  - Make tissues and facemasks available for coughing people.
  - Consider designating staff to steward those supplies and encourage appropriate use by residents, visitors, and staff.
- Make necessary Personal Protective Equipment (PPE) available in areas where resident care is provided. Put a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room, or before providing care for another resident in the same room. Facilities should have supplies of:
  - facemasks
  - respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP)
  - gowns
  - gloves
  - eye protection (i.e., face shield or goggles).
- Environmental cleaning and disinfection:
  - Make sure that EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
  - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.

Assessing Risk & Possible Restrictions for HCP

Refer to the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).

Evaluate and Manage HCP with Symptoms of Respiratory Illness

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill HCP to stay home.
- As part of routine practice, ask HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection.
  - Remind HCP to stay home when they are ill.
  - If HCP develop fever or symptoms of respiratory infection while at work, they should immediately put on a facemask, inform their supervisor, and leave the workplace.
  - Consult occupational health on decisions about further evaluation and return to work.
- Screen all HCP at the beginning of their shift for fever and respiratory symptoms.
  - Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home.

- HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.

- Restrict nonessential healthcare personnel (including consultant personnel) and volunteers for entering the building.
- When transmission in the community is identified, nursing homes and assisted living facilities may face staffing shortages. Facilities should develop (or review existing) plans to mitigate staffing shortages.

When to End Transmission-Based Precautions

Refer to the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19.

Policies and Procedures for Visitors

- Because of the ease of spread in a long-term care setting and the severity of illness that occurs in residents with COVID-19, facilities should immediately restrict all visitation to their facilities except for end-of-life situations.
  - Send letters or emails to families advising them that no visitors will be allowed in the facility except for end-of-life situations. Facilitate alternative methods for visitation (e.g., video conferencing).
  - Post signs at the entrances to the facility advising that no visitors may enter.
- Make decisions about visitation during an end-of-life situation on a case-by-case basis, which should include careful screening of the visitor for fever or respiratory symptoms. When allowed, visitors must wear facemasks while in the building and restrict visits to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

Resources for Confirmed or Suspected COVID-19

- Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19)
- Evaluating and Reporting Persons Under Investigation (PUI)

Evaluate and Manage Residents with Symptoms of Respiratory Infection

- Ask residents to report if they feel feverish or have symptoms of respiratory infection.
- Actively monitor all residents upon admission and at least daily for fever and respiratory symptoms (shortness of breath, new or change in cough, and sore throat).
  - If positive for fever or symptoms, implement recommended IPC practices.
- The health department should be notified about residents with sever respiratory infection, or a cluster (e.g., ≤3 residents or HCP with new-onset respiratory symptoms over 72 hours) of residents with symptoms of respiratory infections.
  - See State-Based Prevention Activitiesfor contact information for the healthcare-associated infections program in each state health department.
  - CDC has resources for performing respiratory infection surveillance in long-term care facilitiespdf icon during an outbreak.
- In general, when caring for residents with **undiagnosed respiratory infection** use Standard, Contact, and Droplet Precautions with eye protection **unless the suspected diagnosis requires Airborne Precautions** (e.g., tuberculosis). This includes restricting residents with respiratory infection to their rooms. If they leave the room, residents should wear a facemask (if tolerated) or use tissues to cover their mouth and nose.
  - Continue to assess the need for Transmission-Based Precautions as more information about the resident's suspected diagnosis becomes available.

- **If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community,**

- Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
- Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.
- Facilities should notify the health department immediately and follow the Interim Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings, which includes detailed information regarding recommended PPE.

- If a resident requires a higher level of care or the facility cannot fully implement all recommended precautions, the resident should be transferred to another facility that is capable of implementation. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.
  - While awaiting transfer, symptomatic residents should wear a facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE should be used by healthcare personnel when coming in contact with the resident.

Additional Measures

- Cancel all field trips, group activities in the facility and communal dining.
- Remind residents to practice social distancing and perform frequent hand hygiene.
- Create a plan for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units.

In addition to the actions described above, these are things facilities should do when there are cases in their community but none in their facility.

Healthcare Personnel Monitoring and Restrictions

- Consider implementing universal use of facemasks for HCP while in the facility.

In addition to the actions described above, these are things facilities should do when there are cases in their facility or sustained transmission in the community.

Healthcare Personnel Monitoring and Restrictions:

- Implement universal use of facemask for HCP while in the facility.

Resident Monitoring and Restrictions:

- Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes.
  - If they leave their room, residents should wear a facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others).
- Implement protocols for cohorting ill residents with dedicated HCP.

Additional Resources

COVID-19 Hospital Preparedness Checklist, including long-term acute care hospitals

Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities

CMS Emergency Preparedness & Response Operations

Page last reviewed: March 10, 2020

Exhibit H

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

DATE: March 21, 2020

TO: Nursing Homes (NHs) and Adult Care Facilities (ACFs)

FROM: NYSDOH Bureau of Healthcare Associated Infections (BHAI)

Health Advisory: Respiratory Illness in Nursing Homes and Adult Care Facilities in Areas of Sustained Community Transmission of COVID-19

Please distribute immediately to:
Administrators, Infection Preventionists, Medical Directors, and Nursing Directors

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.

Facilities should continue to seek advice from their Regional Epidemiologists as needed.

General questions or comments about this advisory can be sent to icp@health.ny.gov, covidadultcareinfo@health.ny.gov, and/or covidnursinghomeinfo@health.ny.gov.

Exhibit I

PRESS RELEASE

Department of Justice Requesting Data From Governors of States that Issued COVID-19 Orders that May Have Resulted in Deaths of Elderly Nursing Home Residents

Wednesday, August 26, 2020

For Immediate Release

Office of Public Affairs

Data will help inform whether the Department of Justice will initiate investigations under the Civil Rights of Institutionalized Persons Act (CRIPA) regarding New York, New Jersey, Pennsylvania and Michigan's response to COVID-19 in public nursing homes

Today the Justice Department requested COVID-19 data from the governors of states that issued orders which may have resulted in the deaths of thousands of elderly nursing home residents. New York, New Jersey, Pennsylvania, and Michigan required nursing homes to admit COVID-19 patients to their vulnerable populations, often without adequate testing.

For example, on March 25, 2020, New York ordered: "No resident shall be denied re-admission or admission to [a nursing home] solely based on a confirmed or suspected diagnosis of COVID-

19. [Nursing homes] are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission."

"Protecting the rights of some of society's most vulnerable members, including elderly nursing home residents, is one of our country's most important obligations," said Assistant Attorney General for Civil Rights Division Eric Dreiband. "We must ensure they are adequately cared for with dignity and respect and not unnecessarily put at risk."

According to the Centers for Disease Control, New York has the highest number of COVID-19 deaths in the United States, with 32,592 victims, many of them elderly. New York's death rate by population is the second highest in the country with 1,680 deaths per million people. New Jersey's death rate by population is 1,733 deaths per million people – the highest in the nation. In contrast, Texas's death rate by population is 380 deaths per million people; and Texas has just over 11,000 deaths, though its population is 50 percent larger than New York and has many more recorded cases of COVID-19 – 577,537 cases in Texas versus 430,885 cases in New York. Florida's COVID-19 death rate is 480 deaths per million; with total deaths of 10,325 and a population slightly larger than New York.

The Department of Justice's Civil Rights Division is evaluating whether to initiate investigations under the federal "Civil Rights of Institutionalized Persons Act" (CRIPA), which protects the civil rights of persons in state-run nursing homes, among others. The Civil Rights Division seeks to determine if the state orders requiring admission of COVID-19 patients to nursing homes is responsible for the deaths of nursing home residents.

On March 3, 2020, the Attorney General announced the Justice Department's National Nursing Home Initiative. This is a comprehensive effort by the department, led by the Elder Justice Initiative and in strong partnership with the U.S. Department of Health and Human Services that uses every available tool to pursue nursing homes that provide substandard care to their residents. As announced on April 10, 2020, the department is also investigating the Soldiers' Home in Holyoke, Massachusetts, where COVID-19 has taken the lives of at least 76 residents. https://www.justice.gov/opa/pr/federal-investigation-conditions-nursing-home-veterans-massachusetts-announced

The data requests and Soldiers' Home investigation are not accusations of fault or wrongdoing by the states or any other individual or entity, and the department has not reached any conclusions about these matters.

Updated August 26, 2020

Attachments

Letter to Governor Cuomo [PDF, 209 KB]

Letter to Governor Murphy [PDF, 211 KB]

Letter to Governor Wolf [PDF, 212 KB]

Letter to Governor Whitmer [PDF, 209 KB]

Topics

ELDER JUSTICE | CIVIL RIGHTS

Component

Civil Rights Division

Press Release Number: 20-828

Related Content

PRESS RELEASE

Justice Department to Monitor Compliance with Federal Voting Rights Laws in Rhode Island

The Justice Department announced today that it will monitor compliance with federal voting rights laws in the City of Pawtucket (in Providence County), Rhode Island, for the Sept. 10 primary…

September 6, 2024

BLOG POST

Justice Department's Civil Rights Division Highlights Efforts to Combat Hate Crimes Targeting Black People

Next month is the 15th anniversary of the Matthew Shepard & James Byrd Jr. Hate Crimes Prevention Act, a landmark law that the Justice Department's Civil Rights Division has used…

September 5, 2024

PRESS RELEASE

Justice Department Announces Civil Rights Investigation into Correctional Staff Sexual Abuse at Two California Prisons

The Justice Department announced today that it has opened an investigation into the conditions of two prison facilities operated by the California Department of Corrections and Rehabilitation (CDCR): Central California…

September 4, 2024

Office of Public Affairs

U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington DC 20530

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202-514-2007

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202-514-2000

U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

August 26, 2020

The Honorable Andrew Cuomo
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

Dear Governor Cuomo:

I write to request information regarding COVID-19 and nursing homes run by, or for, the State of New York, as defined in more detail hereafter. The Civil Rights Division of the Department of Justice enforces the Civil Rights of Institutionalized Persons Act (CRIPA). *See* 42 U.S.C. § 1997. The Division is evaluating whether to open a CRIPA investigation of institutions "providing skilled nursing, intermediate or long-term care, or custodial or residential care" that are "owned, operated, or managed by, or provide[] services on behalf of [New York] or [a] political subdivision of [New York]" ("Public Nursing Homes").

To help us make this determination, the Division respectfully requests the following documents and information for each Public Nursing Home. Data should be provided on a Public Nursing Home-specific basis for each Public Nursing Home in the state.

1. The number of Public Nursing Home residents, employees, other staff, guests, and visitors who contracted COVID-19, regardless of where such persons contracted COVID-19.

2. The number of Public Nursing Home residents, employees, other staff, guests, and visitors who died of COVID-19 including those who died in a Public Nursing Home or after being transferred to a hospital or other medical facility, hospice, home care, or any other location.

3. All State-issued guidance, directives, advisories, or executive orders regarding admission of persons to Public Nursing Homes, including those previously superseded, as well as the dates each such document was in effect.

4. The number of persons who were admitted to a Public Nursing Home from a hospital or any other facility, hospice, home care, or other location after testing positive for COVID-19 during the period the guidance or orders were in effect.

We have not reached any conclusions about this matter. In the Division's many years of enforcing CRIPA, the good faith efforts of state, county, or local jurisdictions working with us have enabled us to resolve many matters amicably. We request the above information within 14 days.

If you have any questions, please contact our office.

Sincerely,

Eric S. Dreiband

Eric Dreiband
Assistant Attorney General
Civil Rights Division

U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

August 26, 2020

The Honorable Gretchen Whitmer
Governor of Michigan
P.O. Box 30013
Lansing, Michigan 48909

Dear Governor Whitmer:

I write to request information regarding COVID-19 and nursing homes run by, or for, the State of Michigan, as defined in more detail hereafter. The Civil Rights Division of the Department of Justice enforces the Civil Rights of Institutionalized Persons Act (CRIPA). *See* 42 U.S.C. § 1997. The Division is evaluating whether to open a CRIPA investigation of institutions "providing skilled nursing, intermediate or long-term care, or custodial or residential care" that are "owned, operated, or managed by, or provide[] services on behalf of [Michigan] or [a] political subdivision of [Michigan]" ("Public Nursing Homes").

To help us make this determination, the Division respectfully requests the following documents and information for each Public Nursing Home. Data should be provided on a Public Nursing Home-specific basis for each Public Nursing Home in the state.

1. The number of Public Nursing Home residents, employees, other staff, guests, and visitors who contracted COVID-19, regardless of where such persons contracted COVID-19.

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We have not reached any conclusions about this matter. In the Division's many years of enforcing CRIPA, the good faith efforts of state, county, or local jurisdictions working with us have enabled us to resolve many matters amicably. We request the above information within 14 days.

If you have any questions, please contact our office.

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Assistant Attorney General
Civil Rights Division

U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

August 26, 2020

The Honorable Phil Murphy
Governor of New Jersey
Office of the Governor
P.O. Box 001
Trenton, NJ 08625

Dear Governor Murphy:

I write to request information regarding COVID-19 and nursing homes run by, or for, the State of New Jersey, as defined in more detail hereafter. The Civil Rights Division of the Department of Justice enforces the Civil Rights of Institutionalized Persons Act (CRIPA). *See* 42 U.S.C. § 1997. The Division is evaluating whether to open a CRIPA investigation of institutions "providing skilled nursing, intermediate or long-term care, or custodial or residential care" that are "owned, operated, or managed by, or provide[] services on behalf of [New Jersey] or [a] political subdivision of [New Jersey]" ("Public Nursing Homes").

To help us make this determination, the Division respectfully requests the following documents and information for each Public Nursing Home. Data should be provided on a Public Nursing Home-specific basis for each Public Nursing Home in the state.

1. The number of Public Nursing Home residents, employees, other staff, guests, and visitors who contracted COVID-19, regardless of where such persons contracted COVID-19.

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Eric Dreiband
Assistant Attorney General
Civil Rights Division

U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

August 26, 2020

The Honorable Tom Wolf
Governor of Pennsylvania
Office of the Governor
508 Main Capitol Building
Harrisburg, PA 17120

Dear Governor Wolf:

I write to request information regarding COVID-19 and nursing homes run by, or for, the State of Pennsylvania, as defined in more detail hereafter. The Civil Rights Division of the Department of Justice enforces the Civil Rights of Institutionalized Persons Act (CRIPA). *See* 42 U.S.C. § 1997. The Division is evaluating whether to open a CRIPA investigation of institutions "providing skilled nursing, intermediate or long-term care, or custodial or residential care" that are "owned, operated, or managed by, or provide[] services on behalf of [Pennsylvania] or [a] political subdivision of [Pennsylvania]" ("Public Nursing Homes").

To help us make this determination, the Division respectfully requests the following documents and information for each Public Nursing Home. Data should be provided on a Public Nursing Home-specific basis for each Public Nursing Home in the state.

1. The number of Public Nursing Home residents, employees, other staff, guests, and visitors who contracted COVID-19, regardless of where such persons contracted COVID-19.

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3. All State-issued guidance, directives, advisories, or executive orders regarding admission of persons to Public Nursing Homes, including those previously superseded, as well as the dates each such document was in effect.

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We have not reached any conclusions about this matter. In the Division's many years of enforcing CRIPA, the good faith efforts of state, county, or local jurisdictions working with us have enabled us to resolve many matters amicably. We request the above information within 14 days.

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Sincerely,

Eric S. Dreiband

Eric Dreiband
Assistant Attorney General
Civil Rights Division

Exhibit J

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Nursing home quality, COVID-19 deaths, and excess mortality

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A B S T R A C T

The COVID-19 pandemic in the US has been particularly devastating for nursing home residents. A key question is how have some nursing homes been able to effectively protect their residents, while others have not? Using data on the universe of US nursing homes, we examine whether establishment quality is predictive of COVID-19 mortality. Higher-quality nursing homes, as measured by CMS overall five-star rating, have substantially lower COVID-19 mortality through September of 2020. Quality does not predict the ability to prevent any COVID-19 resident or staff cases, but higher-quality establishments prevent the spread of resident infections conditional on having one. Preventing COVID-19 cases and deaths may come at some cost, as high-quality homes have substantially higher non-COVID deaths. The positive correlation between establishment quality and non-COVID mortality is strong enough that high-quality homes also have more total deaths than their low-quality counterparts and this relationship has grown with time. As of late April 2021, five-star homes have experienced 8.4 percent more total deaths than one-star homes.

I. Introduction

The COVID-19 pandemic in the US has been particularly devastating for residents of nursing homes. As of August 15th, 2021, there were a total of 634,179 COVID-19-related deaths in the US.[1] We estimate that 21 percent of these deaths are among nursing home residents.[2] Through the end of 2020, the death rate for non-nursing home residents was about 87 per 100,000. The death rate for nursing home residents is more than 108 times that number at roughly 9200 per 100,000. The death rate in nursing homes is more 23 times larger than the death rate for those 65 and over outside of nursing homes, which we calculate to be about 390 per 100,000. In at least five states, Rhode Island, Indiana, New Jersey, South Dakota, and Connecticut, more than 12 percent of the nursing home population at the beginning of 2020 had died by the end of the year with COVID-19.

COVID-19 deaths among nursing home patients is heavily influenced by infection and transmission rates in the surrounding community, which varies substantially by region. For example, cumulative non-nursing home COVID-19 deaths rates at the end of 2020 varied from a low of 8 per 100,000 in Vermont to a high of 159 per 100,000 in New Jersey. Yet, community risk alone cannot explain the vast variation in nursing home death rates. Even in the five states mentioned above with the highest nursing home death rates, 17 percent of homes had not experienced a single COVID-19 mortality by the end of 2020. A key research question is then how have some nursing homes been able to effectively protect their residents, while others have not?

In this work, we focus on one particular dimension of the problem: nursing home quality. Starting in 2008, the Centers for Medicare and Medicaid (CMS) began providing a "five-star" rating of nursing home quality based on three elements: health inspections, staff-to-resident ratios, and quality metrics such as rates of falls and bedsores, with the first element having the greatest weight in an "overall" rating. We merge this quality data with data on COVID-19 cases and mortality that is reported weekly by nursing homes to CMS starting the week ending May 24th, 2020. In count-data models that control for local risk factors and nursing home characteristics, we find that the overall rating is highly predictive of mortality, with five-star homes having 15 percent fewer resident COVID-19

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E-mail address: wevans1@nd.edu (W.N. Evans).

[1] https://coronavirus.1point3acres.com/.

[2] We outline the data used in these calculations in the next section.

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deaths by September 13th, 2020 than one-star homes. We find no such relationship between home quality and COVID-19 deaths after September of 2020.

We identify several mechanisms through which quality nursing homes lowered mortality. First, we show that the chance of having any COVID-19 cases among residents or staff is not explained by nursing home quality, meaning even high-quality homes were unable to prevent COVID-19 from entering their facility. That said, in models that condition on having at least one confirmed case, we show that higher-quality nursing homes more successfully prevented the spread of the disease among residents. Unfortunately, we do not have detailed data on the policies and procedures that enabled these establishments to prevent the spread of the disease. We do show that higher-quality homes experienced fewer staff shortages, which may have helped with patient monitoring and isolation, and somewhat weaker evidence of fewer personal protective equipment (PPE) outages. Furthermore, we show that high-quality homes tested residents and staff more frequently and received test results faster than low-quality homes. Consistent with high-quality homes simply following CMS guidelines more closely, we also show that once vaccines were made available, high-quality homes vaccinated residents and staff at a higher rate.

A likely scenario is that higher-quality establishments also did a better job of isolating residents from risks associated with both outside visitors and other residents. On March 13th, 2020, CMS recommended that nursing homes (i) restrict visitors and non-essential personnel from entering the home and (ii) cancel in-person dining and other group activities (CMS, 2020a).[3] These precautions very well may have prevented deaths from COVID-19, but many have questioned whether those gains came at a cost. An abundance of qualitative evidence from nursing home staff, administrators, and resident family members suggests that the lack of in-person contact with loved ones and other residents not only generated feelings of loneliness, isolation, and despair, but may have also expedited death (Aronson, 2020; Paulin, 2020; Graham, 2020). A nationwide survey of nursing home residents by Altarum, a non-profit healthcare company, documents similar concerns (Montgomery et al., 2020). Existing research shows that social isolation increases both dementia severity and the likelihood of adverse outcomes among those with Alzheimer's (Dyer et al., 2020) and mortality among the elderly (Steptoe et al., 2013). According to CDC provisional data, there were 56,464 excess deaths (i.e., realized deaths above that which is predicted using historical averages) among Alzheimer's patients through early October of 2021;[4] however, only 22,709 or 40 percent had a corresponding positive COVID-19 diagnosis,[5] leaving 60 percent of these excess deaths not directly related to the disease but to other aspects of the pandemic.[6]

To investigate this claim, we return to our original model, but change the dependent variable from COVID-19 deaths to non-COVID deaths. We find that higher-quality nursing homes have much higher non-COVID mortality. In particular, as of September 13th, 2020, five-star homes had experienced 11.4 percent more non-COVID deaths than one-star homes, all else equal; by April 15, 2021, this figure had grown to nearly 15 percent. Research by Levere et al. (2020) suggests that these excess deaths likely resulted from isolation and loneliness. Using resident-level assessment data from Connecticut nursing homes, the authors document substantial weight loss and increases in severe pressure ulcers among residents who did *not* contract COVID-19. The resident survey mentioned above also documents severe isolation, finding that only 5 percent of respondents had visitors three or more times per week, compared to 56 percent before the pandemic, and just 13 percent reported dining in a communal setting, compared to 69 percent before the pandemic. Another possibly is that resident contact restrictions may coincide with, or even cause, a reduction in interactions with healthcare providers, both inside and outside the home, which would be consistent with widely documented reductions in healthcare receipt overall during the early stages of the pandemic (Bosworth et al., 2020; Ziedan et al., 2020; Cantor et al., 2020; Clemens et al., 2021).

An alternative explanation of our findings is that there is incomplete reporting of COVID-19 or strategic use of defining COVID-19 deaths by nursing homes to mitigate the damage to their reputation from the CMS reports. To investigate this, in Fig. 1 we report weekly deaths in nursing homes as reported to CMS from the end of May 2020 through June of 2021. Were deaths misreported, we would expect spikes in non-COVID deaths during the summer and winter waves of 2020. Such spikes are not present in the data. Moreover, when we eliminate deaths prior to June of 2020, when misreporting is most likely, our results are unaffected. Another plausible explanation of our findings is "harvesting"; i.e., low-quality homes experience fewer non-COVID deaths because the most fragile residents die from COVID-19. To test this theory, we estimate the impact of nursing home quality on *total* deaths. We find that between January 1st, 2020 and April 25th, 2021, five-star homes experienced 8.4 percent more total deaths than one-star homes, an average difference of 2.7 lives.

Given the number of COVID-19-related deaths and an early understanding that the elderly die at higher rates, there is surprisingly little research on deaths in nursing homes. As a result, this paper contributes to the literature on the health effects of COVID-19 along several dimensions. A number of papers have examined the general relationship between CMS five-star ratings and COVID-19 cases and/or deaths in nursing homes but much of this work was either in a single state (Bui et al., 2020; Harrington et al., 2020; He et al., 2020; Li et al., 2020a) or occurred very early in the pandemic (Abrams et al., 2020). Some studies have used various versions of the CMS data used in this study. Gorges and Konetzka (2020) show that county incidence rates are the strongest predictor of resident mortality and staff levels have modest impacts on the spread of the disease. Li et al. (2020b) document much higher COVID-19 death rates in homes with a larger share of minority patients. Chen et al. (2021) show that contractors that service multiple nursing homes

[3] The Kaiser Family Foundation notes that early in the pandemic, 27 states banned visitors and 22 states recommended that nursing homes ban visitors (Tolbert et al., 2020). Two states provided no guidance.

[4] https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm#data-tables

[5] https://data.cdc.gov/NCHS/Conditions-Contributing-to-COVID-19-Deaths-by-Stat/hk9y-quqm.

[6] While only 12.5 percent of Alzheimer patients live in nursing homes (Lepore et al., 2017), just under half of nursing home residents have Alzheimer's (CDC, 2020a). In 2018, 50.6 percent of all deaths listing Alzheimer's as an underlying cause occurred in nursing homes. (Authors' calculations from CDC Wonder Multiple Cause of Death data.)

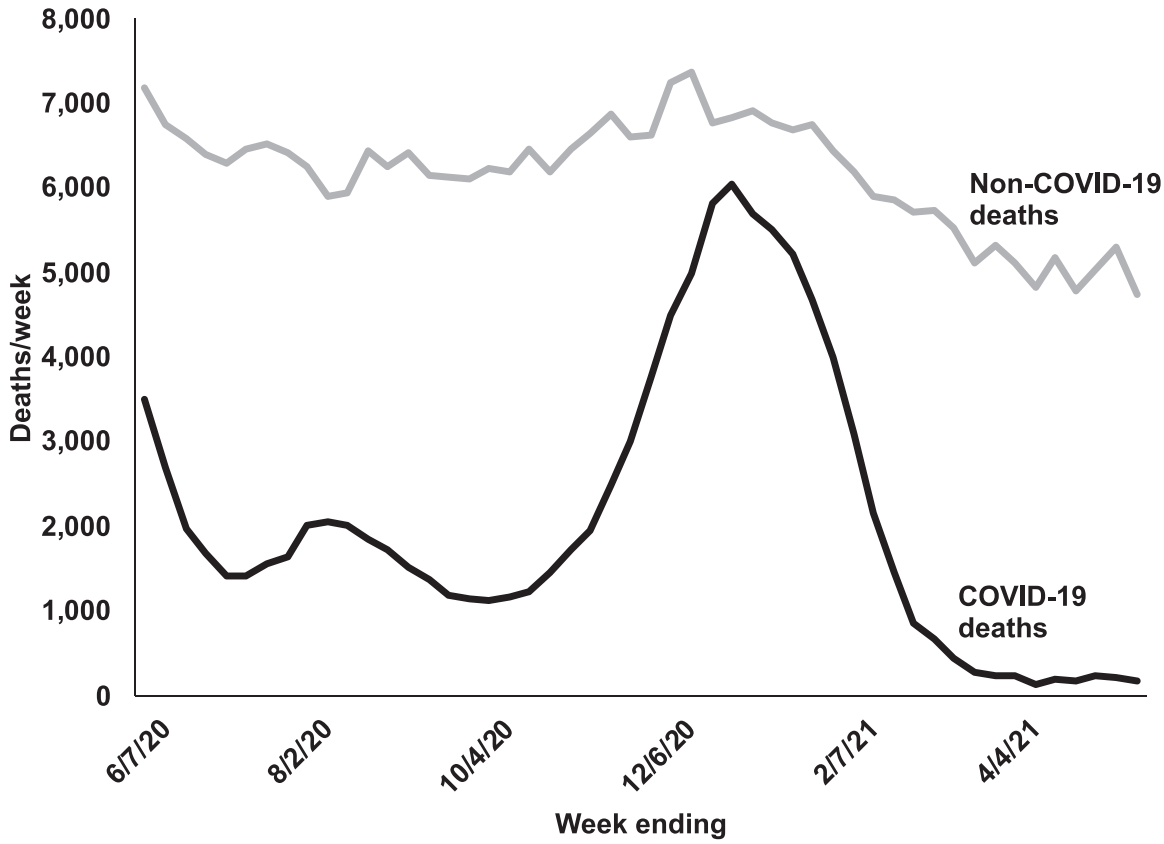

Fig. 1. Deaths by Week Among Nursing Home Residents, May 31st, 2020 through May 9th, 2021
This figure reports the total number of nursing home resident deaths in the US by week, from May 31st, 2020 to May 9th, 2021. Total deaths have been decomposed into those related to COVID-19 or not. Weekly deaths are calculated using the CMS COVID-19 nursing home surveillance survey described in Section II.A .

in a local area helped spread the disease. The data from the CDC showing large excess death rates for the elderly and especially Alzheimer's patients has helped put this issue into the public discussion, yet there is little research other than efforts to document the extent of the problem and almost no research on the factors that lead to excess mortality.

While much of the previous work studies determinants of outbreaks, only a few studies such as (Li, Cen, Cai and Temkin-Greener, 2020b) and Gorges and Konetzka (2020) consider mortality in a nationwide sample as we do. Moreover, we identify that the home quality/COVID-19 death relationship is most likely explained by high-quality homes reducing the spread of the virus once it enters the home and it is not due to a home's ability to prevent the entry of the disease. Importantly, our paper is the first to establish a negative link between nursing home quality and non-COVID mortality. This relationship is so pronounced that high-quality nursing homes are found to have significantly higher *total* mortality than low-quality homes.

The COVID-19 pandemic presented an almost unprecedented challenge for nursing homes. In response to CMS directives and various state regulations, it is without question that the pandemic made nursing homes much lonelier places to live. In this paper, we show that the highest quality nursing homes have witnessed the greatest amount of death during the pandemic. The means by which quality is measured may be important to understanding this finding. Inputs to the CMS five-star rating measure a nursing home's ability to abide by pre-determined guidelines (e.g., staffing ratios) and minimize objectively bad health outcomes (e.g., bed sores). In light of this, it is not clear that homes of high quality, as it is traditionally measured, should fare well in a highly uncertain environment where guidelines from the centralized authority (i.e., CMS), as well as public opinion, attach extraordinary weight to preventing a single bad outcome; namely, COVID-19 cases and deaths. This paper provides a clear example of high-quality homes *underperforming* in such an environment.[7] We offer two takeaways.

[7] There is a public health literature that evaluates the extent to which CMS star ratings measure true quality. Konetzka et al. (2021) review this literature and point to two types of evidence that the overall star rating captures relevant information on quality. The first type of evidence is that the overall star rating is highly predictive of characteristics typically associated with quality, such as the share of Medicaid pay residents and resident education (Konetzka & Gray, 2017; Perraillon et al., 2019), something we document in this paper as well. The second type of evidence shows that homes with higher overall star ratings have fewer hospital admissions and readmissions and lower mortality (Cornell et al., 2019;

First, an organization's capacity to perform well in the face of adversity may be an important dimension of its quality. Such capacity is difficult to measure across organizations because adversity may not be observable and is rarely evenly distributed. The COVID-19 pandemic offers CMS an observable shock that affected all nursing homes. CMS should consider capitalizing on this opportunity by evaluating nursing home responses to the COVID-19 shock and integrating this evaluation into their quality metrics.

Second, through September of 2020, CMS guidelines clearly prioritized reducing nursing home resident exposure to COVID-19. Guidelines focused on proper PPE use, testing protocols, and isolating residents from the outside world and one another. COVID-19 cases and deaths were publicized and widely reported in the news media. Our results suggest that in response, the best nursing homes "hit their marks," i.e., they followed guidelines and, for a time, avoided the bad health outcome of focus. That said, we show that these homes witnessed the most total death in the long-run. In the future, we hope that these findings serve as a reminder that even early guidelines and objective health metrics should be cognizant of resident wellbeing at large.

II. Data

II.A. Data sources and reporting accuracy

Our primary data source is a weekly data set released by CMS that has COVID-19 surveillance information by nursing home. On May 8th, 2020, CMS released a final ruling that required nursing homes to report confirmed and suspected COVID-19 cases of residents and staff to both the residents and their representatives. The ruling also required that nursing homes report weekly totals of surveillance items to the Centers for Disease Control (CDC) National Healthcare Safety Network, starting with the week ending May 24th, 2020. Reporting was mandatory with a $1000 fine issued after four-weeks of non-reporting. Thereafter, fines increased by $500 for each week of non-reporting (CMS, 2020c).

The first weekly file was released by CMS in early June and updates are released on Thursdays, 11 days after the end of the Monday to Sunday reporting period. The initial release of this data set was in a word, messy. There were obvious key-punch errors and variables were frequently reported in the wrong columns. Subsequent releases of the data corrected many of these recording errors and the most recent releases of the data are relatively free from these obvious errors, although some naturally exist. Reporting has always been high. In the first release of the data, 13,162 nursing homes were included and 97 percent passed a data quality assurance check. In the following few weeks, many homes missing the original deadline submitted both current and historic data. The number of homes reporting in a single week peaks at 15,330 for the week ending September 20th, 2020, and 98 percent passed a data quality assurance check. The number never dips below 15,167 after that. Based on the size of the CMS five-star data set, this represents 97 to 98 percent of all nursing homes.

The CMS nursing home data reports weekly and cumulative (since January 1st, 2020) values for confirmed COVID-19 cases for residents and staff, suspected cases for these two groups, and COVID-19 deaths (which includes suspected and confirmed), plus all deaths, among residents. Deaths are reported regardless of the location, so if a nursing home resident is moved to a hospital and dies there, the death is counted as a nursing home resident death. The survey asks nursing homes if they have shortages of key staff including nursing staff, clinical staff, and aids, and whether they have adequate supplies of specific PPE such as N95 masks, surgical masks, gowns, etc. From August 16th through November 22nd (2020), the survey asks a series of questions about COVID-19 testing procedures. Not until late May of 2021 did the survey ask about resident and staff vaccinations.

The CMS nursing home data has an important limitation. At the time of the first report (May 24th, 2020), CMS allowed nursing homes the choice to report cases and deaths from the prior week *or* cumulative cases and deaths since January 1st. Thereafter, homes report weekly counts and a cumulative count is calculated by CMS; thus, if a home fails to report the cumulative count since January 1st on May 24th, the cumulative count that CMS calculates in future weeks is too small. In Appendix Section B, we compare CMS nursing home death counts to those from the COVID-19 Tracking Project, which measures COVID-19 deaths in nursing homes at the state level in 37 states. We calculate that the initial undercount is about 15%. In contrast, the change in COVID-19 deaths between May 24th, 2020 and other dates as reported by these two sources differs by less than 4 percent. In our robustness analysis, we re-estimate our main model using cases and deaths since May 24th, which appears to be more accurately reported across the two samples.

Using these two data sources, we estimate total nursing home COVID-19 deaths in the nation as of August 15, 2021 to be 137,318, which is 21 percent of aggregate mortality (see Table A1 and associated discussion in the Appendix Section B).

The staggering consequences of the pandemic for nursing home residents can be seen when we calculate COVID-19 death rates for residents and compare to the general population through the end of 2020.[8] The death rate (per 100,000 people) for non-nursing home residents is roughly 87. Dividing imputed COVID-19 deaths by the number of nursing home residents alive at the beginning of 2020,[9] the death rate for nursing home residents is about 9200, or about 108 times the rate for the general population. We calculate

Unroe et al., 2012). There is a more nuanced debate regarding the reliability of the component (i.e., inspection, quality metrics, and staff) star ratings. We review this literature in Appendix Section C.

[8] We calculate these numbers through then end of 2020 as it is easiest to obtain a denominator for January of 2020.

[9] The CMS data indicates there are 1.1 million nursing home residents as of the first CMS weekly report and there were about 72,000 deaths from all causes in nursing homes up to that point. Adding these two numbers together gives us roughly 1.2 million nursing home residents at the beginning of the year. This number is an approximation as residents could have moved into a nursing home and died. The CMS data report 107,342 deaths through the week ending January 3rd, 2021. Applying the correction factor from the appendix to take into consideration the underreporting of deaths in the first week, this generates roughly 111,000 COVID-19 deaths in nursing homes in 2020, for a death rate of 9,252.

that the COVID-19 death rate for people 65 and over living outside of nursing homes is 390,[10] meaning the nursing home death rate is about 24 times this number.

II.B. Heterogeneity across nursing homes in COVID-19 mortality

There is tremendous variation across states in the severity with which the pandemic struck nursing homes. Using the CMS data as of the last week of 2020, deaths per 1000 nursing home residents varied from a low of 12.8 in Alaska to a high of 134 in Rhode Island (see Appendix Fig. A3). In the 14 states with the highest death rates, more than 10 percent of the nursing home population died from COVID-19 in 2020.

The risk nursing home residents face from the disease is strongly correlated with the underlying risk in their state. The correlation coefficient between the non-nursing home COVID-19 death rate at the state level and the same value for nursing home residents (from CMS data) is 0.54.

Despite the strong correlation between underlying risk and nursing home deaths, many nursing homes successfully avoid high death rates, even in the hardest hit areas. In counties from the top 10th percentile of total COVID-19 death rates by May 24th, 2020, just over half of nursing homes with more than 100 beds had two or fewer COVID-19 deaths per 100 beds. By April 24th, 2021 this figure was still in excess of 20 percent. Moreover, a disproportionately small share of nursing homes account for the majority of COVID-19 deaths. As of September 2020, the top 5 (1) percent of nursing homes, which is just 754 (151) homes or 8.3 (2.4) percent of the nation's beds, accounted for 39 (14) percent of all COVID-19 deaths in nursing homes. By the end of April 2021, the top 5 (1) percent of nursing homes still accounted for 23 (8) percent of all COVID-19 deaths.

II.C. Analysis sample

The goal of this project is to explore whether observed nursing home characteristics can explain the variation in COVID-19 death rates. In particular, we test whether high-quality nursing homes, as measured by the CMS five-star ratings, did a better job of preventing deaths from COVID-19. Our initial sample contains 15,421 nursing homes reporting data to CMS at any point between May 25th, 2020 and July 18th, 2021. We lose 311 homes to inconsistent reporting and 205 homes because no five-star rating data was available; thus, our main analysis sample consists of 14,905 nursing homes. Sample construction is discussed in Appendix A and summary statistics for these data are shown in Appendix Table A3.

Several variables used in our analysis require explanation. Data on nursing home characteristics comes from "Long-term Care: Facts on Care in the US", which is provided by a research center at Brown University.[11] Sample statistics are reported for observations with non-missing data. The acuity index, which ranges from zero to 23 in the data, measures of the amount of care needed by the average nursing home residents (higher values suggest more care). For the three variables – the share of residents using Medicaid, the acuity index, and for-profit status – the data contains values for all or none of them.

Nursing home star ratings come from data.medicare.gov. There are three separate ratings – inspection, quality measures (QM), and staffing – which are aggregated by CMS into an overall rating.[12] All three ratings, as well as the overall rating, measure quality in integer "star" values, where five-star is the best possible rating and one-star is the worst. We discuss the construction of these ratings and briefly outline the literature that evaluates the ratings in Appendix Section C. In our empirical analysis, we measure quality using the overall five-star rating, reported by CMS in June of 2020. All data informing these ratings was collected prior to March, when it was first recognized that COVID-19 was present and spreading in the United States.

In Table 1, we present cumulative case and death rates over time, starting January 1st, 2020. Throughout our analysis, we focus on cumulative deaths at and between four dates: (i) May 24th, 2020, which precedes the summer 2020 COVID-19 wave and is the first date we observe in the CMS data; (ii) September 13th, 2020, which follows the summer wave, but precedes a September 17th CMS memo that altered visitation protocols in nursing homes (discussed below); (iii) December 6th, 2020, which is the last date available prior to the start of vaccine distribution; and (iv) April 25th, 2021, a point in which nearly all US nursing home residents had a full four months to become vaccinated and COVID-19 death rates in nursing homes had flatlined (see Fig. 1). Resident and staff case variables measure confirmed cases reported to CMS. Nursing homes report both total deaths from any cause and COVID-19 deaths

[10] Census estimates a US population of 329 million in January of 2020, including 54 million people 65 and older (US Census Bureau, 2020). There were 392,356 COVID-19 deaths by the week ending January 2nd, 2021, meaning 281,338 were outside of nursing homes. One estimate suggests 15.5 percent of the nursing home population is under 65 (Howley, 2019), leaving 1 million people aged 65 and over living in nursing homes and 55 million people aged 65 or over living outside of nursing homes. The CDC reports that 96 percent of deaths in nursing homes were to people 65 and older. Applying this ratio to the CMS numbers suggests that roughly 106,577 COVID-19 deaths in nursing homes were to people aged 65 and over. Subtracting this from the 317,020 COVID-19 deaths to people aged 65 and over in the US, there were 210,443 COVID-19 deaths for people aged 65 and over outside of nursing homes, for a death rate of 390. We acknowledge that this figure is likely overstated as the CDC reports place of death (e.g., hospital, at home, nursing home), so the counts for people outside nursing homes in places like hospitals, emergency rooms and hospice facilities would include some nursing home residents as well.

[11] More information can be found at http://ltcfocus.org/.

[12] More details, as well as the methods for calculating the overall rating can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/brieffivestartug.pdf

Table 1
COVID-19 Cases and Death Rates by Cause over Time in Nursing Homes Means (standard deviations).

Variable	As of 5/24/20	As of 9/13/20	As of 12/06/20	As of 4/25/21
Cumulative case and death rates (per 100 beds)				
Resident COVID-19	4.93	12.94	26.17	40.39
case rate	(12.79)	(19.31)	(24.80)	(27.39)
Staff COVID-19 case	2.86	11.11	24.27	38.11
rate	(7.21)	(16.59)	(23.94)	(22.14)
Resident COVID-19	1.30	3.00	5.00	8.10
death rate	(3.69)	(5.77)	(6.90)	(8.57)
Resident	3.12	9.69	14.60	22.25
non-COVID-19 death	(7.69)	(23.88)	(41.85)	(51.87)
rate				
County-level cumulative case and death rates (per 1000 residents)				
COVID-19 cases rate	2.86	15.35	33.75	94.50
	(4.76)	(9.97)	(15.85)	(24.77)
COVID-19 deaths	0.25	0.54	0.89	1.86
rate	(0.42)	(0.54)	(0/61)	(0.86)

This table reports mean, cumulative case and death rates at four points in time. The nursing home case and death rates reported in the top panel come from the CMS COVID-19 nursing home surveillance survey described in Section II.A. Note that the number of resident non-COVID-19 deaths is calculated by subtracting the reported number of COVID-19 deaths from the reported number of total deaths in the home. The county-level case and death rates are calculated using counts from USAFacts (2020).

each week, which allows us to calculate deaths not from COVID-19.[13] Note that case (and death) rates are calculated as (cases/total beds)*100. County-level COVID-19 case and death totals come from the same source used by the CDC (USAFacts, 2020).

In Table 2, we present nursing home characteristics and relevant COVID-19 summary statistics for nursing homes with different overall star ratings as of September 13th, 2020.[14] Many nursing home characteristics change monotonically with the overall star rating including: total beds (decreasing); the share of female residents (increasing); the share of residents under 65, black, Hispanic, and on Medicaid (decreasing), and the acuity index (decreasing). The persistent relationship between these observed characteristics and the overall star rating might mean there is little informational content in the ratings. However, a simple regression of the overall star rating on observed characteristics only produces and R^2 of 0.21. Regarding COVID-19, higher-quality homes have lower resident case rates, but slightly higher staff rates. Moreover, these homes have notably smaller COVID-19 death rates, but higher non-COVID death rates. On average, higher-quality homes have experienced fewer staff shortages and PPE outages than lower-quality homes since May 24th, 2020. COVID-19 testing is not strongly correlated with overall quality.

III. Statistical model and results

We estimate the effect of nursing home quality on the total number of nursing home deaths due to COVID-19 using a negative binomial model. That is, we write the probability of nursing home i having COVID-19 deaths Y_i as

$$\Pr\left(Y_i\right) = \frac{\Gamma\left(Y_i+\gamma_i\right)}{\Gamma\left(Y_i+1\right)\Gamma\left(\gamma_i\right)}\left(\frac{\theta}{1+\theta}\right)^{Y_i}\left(\frac{1}{1+\theta}\right)^{\gamma_i} \tag{1}$$

where $\Gamma(\cdot)$ is a gamma function and γ_i and θ are the shape and scale parameters, respectively, of a gamma distribution. We allow γ_i to vary with nursing home and county characteristics, X_i, such that $\ln(\gamma_i) = X_i\beta$. The parameters (θ, β) are estimated via maximum likelihood. All models include state fixed effects and standard errors are clustered at the state level.

We are primarily interested in the impact that nursing home quality has on COVID-19 deaths; however, we also control for the following: (logged) total number of beds; the percent female, under 65 years old, black, Hispanic, and on Medicaid; whether the home is for profit; acuity index;[15] (logged) county population; and county COVID-19 cases per 1000 residents.[16]

[13] Homes are to report all deaths regardless of location, e.g., in the home or in a hospital (CMS, 2020c). The module instructions (CDC, 2020b) define a COVID-19 death as "a resident with suspected or a positive COVID-19 test result who died in the facility or another location as a result of COVID-19 related complications." The instructions state the following regarding the reporting of marginal COVID-19 deaths: (i) suspected deaths are those that are being managed for COVID-19 symptoms, but do not have a positive test, and these symptoms play a role in their death; (ii) someone without a positive test or symptoms who dies from complications associated with COVID-19 and later has COVID-19 diagnosed in autopsy, should be coded (retrospectively) as a COVID-19 death; (iii) someone previously diagnosed or suspected to be COVID-19 positive, who dies after recovery should *not* be counted as a COVID-19 death.

[14] Other time periods look very similar and are available upon request.

[15] Nursing home characteristics are missing for some homes; thus, we include missing variable indicators as well.

[16] County-level COVID-19 cases are included as a measure of the intensity of the virus locally. As death occurs on average 18.5 days after symptom onset (Zhou et al. 2020) and the incubation period is 4-5 days on average (CDC, 2020c) we measure cases 23 days prior to death. All models are robust to controlling for the county's non-nursing home death rate rather than the case rate.

Table 2
Descriptive Statistics in Nursing Homes, Overall 5-Star Rating.

	1-star	2-star	3-star	4-star	5-star
NH characteristics					
total beds	122.8	116.6	110.4	102.7	88.5
share of female residents	0.621	0.645	0.659	0.681	0.692
share of residents under 65 years old	0.277	0.252	0.233	0.195	0.159
share of black residents	0.271	0.206	0.177	0.127	0.084
share of Hispanic residents	0.072	0.063	0.053	0.038	0.032
share of residents on Medicaid	0.693	0.650	0.630	0.584	0.487
for profit	0.867	0.775	0.735	0.665	0.543
acuity index	12.25	12.22	12.20	12.16	12.14
Cumulative Cases and Deaths (9/13)					
any resident COVID-19 cases?	0.683	0.680	0.650	0.613	0.560
resident COVID-19 cases/100 beds	15.06	15.15	13.35	12.39	10.37
any staff COVID-19 cases?	0.877	0.855	0.854	0.844	0.832
staff COVID-19 case/100 beds	10.40	11.30	11.16	11.02	11.51
any resident COVID-19 deaths?	0.509	0.492	0.455	0.415	0.359
resident COVID-19 death/100 beds	3.324	3.539	2.999	2.922	2.531
any resident deaths not from COVID-19?	0.846	0.857	0.874	0.863	0.831
resident death not from COVID-19/100 beds	8.15	9.35	9.74	9.85	10.87
NH Staff and Supplies (since week ending 5/24)					
any nursing staff shortage?	0.477	0.410	0.383	0.359	0.311
any aide staff shortage?	0.522	0.452	0.428	0.399	0.346
any clinical staff shortage?	0.211	0.182	0.168	0.166	0.151
n95 mask outage?	0.208	0.185	0.177	0.157	0.155
surgical mask outage?	0.119	0.113	0.107	0.101	0.103
eye protection outage?	0.123	0.124	0.118	0.104	0.097
gown outage?	0.126	0.130	0.128	0.112	0.116
glove outage?	0.085	0.070	0.073	0.060	0.065
hand sanitizer?	0.093	0.075	0.068	0.061	0.065
COVID-19 Testing (week ending 9/13)					
average time to test results					
<1 day	0.104	0.086	0.079	0.074	0.076
1–2 days	0.397	0.431	0.460	0.480	0.503
3–7 days	0.465	0.459	0.436	0.430	0.408
>7 days	0.034	0.025	0.025	0.016	0.013
any resident test in past week?	0.556	0.612	0.617	0.619	0.607
any staff test in past week?	0.799	0.822	0.816	0.818	0.808
testing machine on site?	0.695	0.688	0.685	0.685	0.618
Observations	2279	2918	2684	3221	3803

This table reports average nursing home characteristics and COVID-19 metrics by the nursing home's CMS overall star rating. We measure overall star rating for each nursing home as reported in June of 2020, which is available for download on the CMS website. All nursing home characteristics, except total number of beds, are taken from the LTC Focus database at Brown University. Total number of beds and all COVID-19 metrics come from the CMS COVID-19 nursing home surveillance data described in Section II.A. Case/Death information and Staff/Supply information are measured through September 13th, 2020; later dates are available upon request. Testing variables are reported for a single week (the week ending September 13th, 2020), as most testing-related questions were only asked from August 16th through November 22nd of 2020.

Table 3
Negative Binomial Estimates, Impact of Overall Star Ranking on Deaths in Nursing Homes.

		Coefficients (standard errors) on Overall star ranking			
Period of analysis	Sample mean	2-star	3-star	4-star	5-star
			COVID-19 deaths		
(1) As of 5/24/20	1.702	0.000	−0.164	−0.142	−0.173
		(0.048)	(0.068)	(0.073)	(0.065)
(2) As of 9/13/20	3.670	0.033	−0.073	−0.092	−0.154
		(0.034)	(0.052)	(0.047)	(0.056)
(3) As of 12/06/20	5.570	0.019	−0.045	−0.040	−0.094
		(0.023)	(0.033)	(0.035)	(0.036)
(4) As of 4/25/21	8.704	0.026	−0.019	0.003	−0.072
		(0.024)	(0.034)	(0.030)	(0.032)
(5) Δ 9/13/20 – 5/24/20	1.969	0.001	−0.066	−0.096	−0.211
		(0.042)	(0.057)	(0.053)	(0.057)
(6) Δ 12/06/20 – 9/13/20	1.899	−0.005	0.001	0.008	−0.004
		(0.039)	(0.039)	(0.046)	(0.048)
(7) Δ 4/25/21 – 12/06/20	3.135	0.045	0.056	0.058	0.023
		(0.034)	(0.046)	(0.044)	(0.051)
			Non-COVID-19 deaths		
(8) As of 5/24/20	3.381	0.013	0.015	0.030	0.038
		(0.050)	(0.050)	(0.050)	(0.059)
(9) As of 9/13/20	10.146	0.034	0.070	0.088	0.114
		(0.029)	(0.031)	(0.034)	(0.041)
(10) As of 12/06/20	15.383	0.032	0.074	0.105	0.123
		(0.025)	(0.025)	(0.030)	(0.032)
(11) As of 4/25/21	23.170	0.055	0.092	0.127	0.148
		(0.019)	(0.021)	(0.025)	(0.030)
(12) Δ 9/13/20 – 5/24/20	6.765	0.039	0.079	0.103	0.137
		(0.026)	(0.028)	(0.030)	(0.033)
(13) Δ 12/06/20 – 9/13/20	5.236	0.059	0.135	0.175	0.200
		(0.023)	(0.024)	(0.029)	(0.031)
(14) Δ 4/25/21 – 12/06/20	7.787	0.098	0.150	0.202	0.239
		(0.023)	(0.028)	(0.033)	(0.036)
			All deaths		
(15) As of 5/24/20	5.082	0.010	−0.007	0.013	0.010
		(0.043)	(0.041)	(0.046)	(0.056)
(16) As of 9/13/20	13.816	0.025	0.027	0.045	0.050
		(0.028)	(0.030)	(0.033)	(0.039)
(17) As of 12/06/20	20.952	0.027	0.031	0.064	0.061
		(0.022)	(0.021)	(0.027)	(0.030)
(18) As of 4/25/21	31.874	0.047	0.055	0.084	0.084
		(0.017)	(0.018)	(0.023)	(0.026)
(19) Δ 9/13/20 – 5/24/20	8.734	0.029	0.035	0.053	0.066
		(0.028)	(0.030)	(0.029)	(0.036)
(20) Δ 12/06/20 – 9/13/20	7.136	0.049	0.102	0.134	0.153
		(0.023)	(0.020)	(0.029)	(0.031)
(21) Δ 4/25/21 – 12/06/20	10.922	0.085	0.121	0.159	0.175
		(0.018)	(0.028)	(0.035)	(0.035)

Standard errors allow for arbitrary correlation across observations within a state. Other controls in the models include logged total beds; percent of residents that are female, under 65, black, Hispanic, on Medicaid (along with corresponding indicators for missing variables); for-profit status; acuity index; county-level COVID-19 cases per 1000 residents (measured 23 days prior to death); logged county population; and a full set of state fixed effects.

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III.A. COVID-19 mortality results

We estimate Eq. (1) across several different time periods. We report parameter estimates for the impact of nursing home quality, measured using the overall star rating, on COVID-19 deaths in the first seven rows of Table 3. [17] The first four rows use cumulative

[17] Results are very similar if the inspection rating is used in place of the overall rating. Results for all quality measures are available upon request.

Table 4
Robustness Analysis, deaths measured 9/13 unless stated otherwise.

			Overall Star Rating			
Model	Sample mean	Obs	2-star	3-star	4-star	5-star
(1) Baseline (Table 3, row 2)	3.67	14,905	0.033	−0.073	−0.092	−0.154
			(0.034)	(0.052)	(0.047)	(0.056)
(2) Model (1), but Poisson	3.67	14,905	0.052	−0.126	−0.100	−0.169
			(0.048)	(0.064)	(0.052)	(0.054)
(3) Model (1) but OLS with ln(deaths+1)	0.82	14,905	0.030	−0.036	−0.042	−0.074
			(0.022)	(0.031)	(0.024)	(0.031)
(4) Model (3) but add county FE	0.82	14,905	0.024	−0.068	−0.061	−0.096
			(0.028)	(0.040)	(0.030)	(0.036)
(5) Model (1) but OLS with inverse hyperbolic sine of deaths	1.02	14,905	0.034	−0.043	−0.053	−0.094
			(0.028)	(0.039)	(0.030)	(0.038)
(6) Model (5) but add county FE	1.02	14,905	0.026	−0.082	−0.076	−0.121
			(0.034)	(0.049)	(0.037)	(0.044)
(7) Model (1) but OLS with inverse hyperbolic sine of death rate (per 100 beds)	1.02	14,905	0.034	−0.043	−0.053	−0.094
			(0.028)	(0.039)	(0.030)	(0.038)
(8) Model (7) but add county FE	1.02	14,905	0.026	−0.082	−0.076	−0.121
			(0.034)	(0.049)	(0.037)	(0.044)
(9) Model (1) but add controls for staff hours per resident day	3.67	14,558	0.038	−0.071	−0.079	−0.124
			(0.034)	(0.051)	(0.047)	(0.056)
(10) Model (1) but add controls for republican share of county	3.67	14,888	0.033	−0.073	−0.091	−0.154
			(0.034)	(0.052)	(0.047)	(0.055)
(11) Model (1) but add controls for any staff and resident cases, as well as counts	3.67	14,905	−0.045	−0.082	−0.169	−0.229
			(0.038)	(0.031)	(0.046)	(0.058)
(12) Model (1) but add controls for shortage counts	3.67	14,905	0.043	−0.060	−0.076	−0.136
			(0.033)	(0.051)	(0.045)	(0.054)

Standard errors allow for arbitrary correlation across observations within a state. Other controls in the models include logged total beds; percent of residents that are female, under 65, black, Hispanic, on Medicaid (along with corresponding indicators for missing variables); for-profit status; acuity index; county-level COVID-19 cases per 1000 residents (measured 23 days prior to death); logged county population; and a full set of state fixed effects.

counts of COVID-19 deaths, starting January 1st, 2020 through May 24th, September 13th, December 6th (of 2020), and finally April 25th (of 2021).

Our results show that through September 13th, 2020, higher-quality nursing homes experienced fewer deaths from COVID-19. For example, nursing homes with a five-star rating had a COVID-19 death rate that was about 15 percent lower than those with a one-star rating. Rows 3 and 4 show that five-star homes experienced statistically fewer cumulative COVID-19 deaths than lower-quality homes as of December 6th, 2020 and April 25th, 2021; however, these effects are driven entirely by deaths leading up to September, as is shown in rows 6 and 7.[18]

We discuss above that the CMS data likely undercounts the true number of COVID-19 deaths in nursing homes, as homes were given the choice on May 24th to report deaths from the prior week or cumulative deaths since January 1st. To show that our results are not somehow driven by this measurement error, in row 5 we change the dependent variable to deaths between September 13th and May 24th (of 2020), which should be measured accurately in the CMS data. These results are similar to our cumulative September 13th findings. Estimated quality effects as of May 24th are also very similar to the results for mid-September (row 1).

We will return to the other two sets of results in Table 3 later in Section III.C

In Table 4 we show that our main findings – the impact of overall star quality on cumulative COVID-19 deaths as of September 13th, 2020 – are robust to a number of alternative empirical specifications, including (row 2) using a Poisson model with clustered standard errors, as suggested by Cameron and Trivedi (2005); using linear models with (row 3) ln(deaths+1), (row 5) the inverse hyperbolic sine of deaths, or (row 7) the inverse hyperbolic sine of death *rates* as the dependent variable; (rows 4, 6, 8) adding county fixed effects to any of the prior three models; (row 9) adding controls for staff hours per resident day, which may be correlated with home quality conditional on number of beds; and (row 10) adding controls for the county's republican vote share in the 2016 presidential election, which others have found is negatively correlated with COVID-19 precaution taking, such as compliance with stay-at-home orders (Charoenwong et al., 2020) and vaccination rates (Agarwal et al., 2021).[19] We will discuss the results in row (11) and (12) below.

[18] Across the seven specifications, we find that homes with more beds, larger black populations, and located in larger cities with higher case rates nearly always have more COVID-19 deaths, while homes with younger populations have fewer deaths. We also find that for-profit homes have significantly more deaths. These results are available upon request.

[19] We obtained 2016 presidential vote share data from https://electionlab.mit.edu/data.

III.B. Mechanisms

How did high-quality nursing homes manage to prevent COVID-19 deaths? CMS first offered nursing homes and assisted living facilities guidelines for preventing and managing COVID-19 cases on March 13th, 2020. Since then, these guidelines have been updated and expanded repeatedly as the public health community has learned more about the virus. The CDC's advice is expansive but is linked by several common themes (CDC, 2020d): First, keep COVID-19 out by limiting visitors and encouraging staff to stay home when ill. Second, clean hands, surfaces, and equipment thoroughly and repeatedly. Third, staff should closely monitor residents for signs of the virus, test symptomatic individuals and close contacts, and isolate those who are symptomatic. Fourth, staff should use PPE at all times. Fifth, after vaccines became available in December of 2020, all residents and staff should be vaccinated.

These recommendations guide our exploration of the potential mechanisms that enabled higher-quality nursing homes to prevent COVID-19 deaths. First, we examine whether higher-quality nursing homes were better able to prevent COVID-19 from entering the home at all. In the first block of results in Table 5 we report results from linear probability models that regress an indicator of whether a home has a single COVID-19 case among its staff (row 1) or among its residents (row 3) as of September 13th, 2020 on the home's overall star rating and the same set of covariates from our earlier analysis. These results show that higher-quality nursing homes, despite lowering the death rate, were not able to prevent COVID-19 from entering the home. Second, we test whether higher-quality nursing homes were able to prevent the spread of the virus, conditional on having at least one case. In rows 2 (4) of Table 5, we report estimates from a linear regression of log staff (resident) cases on the overall rating and covariates, only for homes with at least one staff (resident) case. The results show that while higher-quality nursing homes were not more effective that lower-quality homes in preventing the spread of COVID-19 among their staff, these homes were more effective at preventing the virus' spread among their residents. Conditional on having at least one case, all else equal, five-star homes saw roughly 15 percent fewer cases than one-star homes. As of September 13th, among homes with at least one case, the average home has 24.5 cases per 100 beds, meaning this difference amounts to about 3.7 cases per 100 beds.[20]

In the second block of results in Table 5, we re-estimate the models from rows (1) through (4) but use cases occurring between September 13th, 2020 and April 25th, 2021. The fraction of homes with any staff and resident cases is nearly one, as the winter wave is in the middle of this time period, so it is not a surprise that the quality measure explains little for these outcomes. Consistent with our COVID-19 deaths results earlier, past September there is no difference between low- and high-quality homes in terms of resident COVID spread.[21]

If high-quality nursing homes prevented deaths not by keeping COVID-19 out of the nursing home entirely, but by preventing spread among residents within the home, the next obvious question is: how? We test several plausible theories. First, both identifying and isolating residents with COVID-19 symptoms requires a capable staff that is of an adequate size; thus, we first test whether high-quality nursing homes have had fewer staffing shortages during the pandemic, which may explain their ability to prevent COVID-19 cases among their residents.

In Panel A of Table 6, we present results from three linear probability models that regress indicators for self-reported staffing shortages (nurses, aides, and clinical staff) at any point between May 24th and September 13th of 2020 on the overall star rating and other controls. Row 1 shows that, all else equal, five-star facilities were 10.7 percentage points less likely to have a nursing shortage over this time period than a one-star facility. The gap is 11.8 percentage points for aides (row 2) and 3.9 percentage points for clinical staff (row 3). All effects are statistically significant at the one-percent level. The estimates are 28, 28, and 23 percent, respectively, of the sample mean for the outcomes.

Nursing homes may also prevent the spread of COVID-19 by following the CDC recommendation that all nursing home staff use PPE and wash their hands frequently. While these behaviors cannot be observed in our data, we are able to measure shortages in PPE (n95 masks, surgical masks, eye protection, gowns, and gloves) and hand sanitizer; thus, we test whether higher-quality facilities were less likely to have experienced such shortages between May 24th and September 13th of 2020.[22] We again use linear probability models and control for the same set of potential confounders as above. Results are presented in Panel B of Table 6. For all five forms of PPE and hand sanitizer, the impact of quality is modest. There is suggestive evidence that higher-quality facilities have fewer

[20] We explored an additional, related mechanism – that higher-quality nursing homes provided better care conditional on infections, leading to a lower death rate. To do so, we returned to Equation 1, but controlled (separately) for whether any staff or residents had tested positive for COVID-19, as well as the total number of staff and resident cases. If high-quality facilities only prevent death by reducing cases, then we would expect quality to have no impact on death counts in this model. Estimates can be found in Table 4, row 11. Conditional on cases, higher-quality facilities still have far fewer deaths. This could mean that higher-quality homes reduce mortality by doing a better job of managing COVID-19 cases, that is, they monitor patients closer, are more aggressive at seeking treatment, etc.

[21] As of September 13th, 2020, one-star homes reported significantly fewer staff cases, conditional on having a single staff case. By April 25th, 2021, the staff cases were increasing with the star rating throughout the rating distribution. This somewhat unintuitive result is likely explained by higher-quality homes simply testing their staff more frequently and, thus, measuring more cases. We will provide evidence of this below.

[22] We note the possibility that facilities could have shortages of PPE because the staff is more aggressive at using this equipment. Moreover, as COVID-19 is primary spread through the air, gown, glove, and sanitizer shortages likely have little impact on disease transmission. At the same time, shortages of basic PPE may signal something about the quality of the home's management and the home's general adherence to COVID-19 protocols; hence, we present the results for these types of PPE as well.

Table 5
Negative Binomial Estimates, Impact of Overall Star Ranking on Non-COVID Deaths in Nursing Homes.

			Coefficients (standard errors) on Overall star rating			
Period of analysis	Obs.	Sample mean	2-star	3-star	4-star	5-star
			As of 9/13/2020			
(1) Any staff cases?	14,905	0.850	−0.010	−0.005	0.000	0.000
			(0.008)	(0.010)	(0.009)	(0.013)
(2) ln(staff cases)	12,669	2.044	0.088	0.011	0.046	0.072
			(0.027)	(0.021)	(0.029)	(0.030)
(3) Any resident cases?	14,905	0.629	0.024	0.014	0.009	−0.005
			(0.010)	(0.010)	(0.010)	(0.010)
(4) ln(resident cases)	9392	2.385	0.027	−0.095	−0.087	−0.147
			(0.040)	(0.047)	(0.049)	(0.040)
			From 9/13/2020 to 4/25/2021			
(5) Any staff cases?	14,891	0.993	−0.001	0.001	0.000	0.002
			(0.002)	(0.002)	(0.002)	(0.001)
(6) ln(staff cases)	14,782	9.959	0.031	0.084	0.116	0.146
			(0.022)	(0.025)	(0.023)	(0.030)
(7) Any resident cases?	14,891	0.910	0.009	0.010	0.018	0.010
			(0.008)	(0.007)	(0.009)	(0.009)
(8) ln(resident cases)	13,516	2.849	−0.010	0.018	0.036	−0.015
			(0.035)	(0.041)	(0.035)	(0.044)

Standard errors allow for arbitrary correlation across observations within a state. Other controls in the models include logged total beds; percent of residents that are female, under 65, black, Hispanic, on Medicaid (along with corresponding indicators for missing variables); for-profit status; acuity index; county-level COVID-19 cases per 1000 residents (measured 23 days prior to death); logged county population; and a full set of state fixed effects.

shortages of all equipment except gowns, but effects are only statistically significant for a subset of coefficients in the N95 mask, glove, and hand sanitizer regressions.[23]

Higher-quality homes may also do a better job of testing residents for the virus. Fortunately, the CMS data allows us to generate a number of measures of testing intensity and speed.[24] First, nursing homes report for the week ending September 13th that receiving test results takes "less than a day", "between one and two days", "three-to-seven days", or "more than seven days." Second, nursing homes report whether they tested any asymptomatic residents during the week ending September 13th *in response to* a new positive case.[25] Third, homes report whether they have tested asymptomatic staff or residents when there is no knowledge of exposure. Finally, homes report whether they have their own testing machine.

In Panel C of Table 6, we present estimates of the effect of nursing home quality on these testing measures. We find that higher-quality homes receive test results faster than lower-quality homes (row 1) but these effects are not precisely estimated. Higher-quality homes are statistically more likely to test asymptomatic residents (row 2) and staff (row 3) following a new case; they are also statistically more likely to have ever tested non-exposed residents (row 4), but are no more likely to test non-exposed staff (row 5). There is no relationship between home quality and the likelihood of having an in-home testing machine (row 6).

Finally, we examine whether higher-quality homes were more likely to vaccinate residents and staff. Starting with the May 30th, 2021 survey, CMS began to ask nursing homes about the number of residents and staff that were fully vaccinated. In Panel D of Table 6, we report results from regressions that have the share of current residents and staff vaccinated as of June 20th, 2021 as the outcomes of interest. Here, there is a monotonic relationship between facility quality and vaccination rates. All else equal, resident and staff vaccination rates are 5.6 and 8.3 percentage points higher in five-star homes than in one-star homes. Both results are statistically significant at conventional levels and represent 7 and 14.6 percent increases, respectively, over the sample means of these outcomes.

Overall, higher-quality nursing homes prevent COVID-19 deaths, not by preventing the disease from entering the home, but by preventing its spread among residents. The methods by which homes prevent the spread are consistent with CDC guidelines. Higher-quality homes had more testing, got tests results faster, and had fewer PPE and staff outages. Given that the negative association between home quality and COVID-19 deaths does not persist past September of 2020, higher vaccination rates at high-quality homes clearly cannot explain the relationship. That said, we take the vaccination results as further evidence that high-quality homes followed CDC guidance along observable dimensions and, thus, likely followed along unobservable dimensions as well.

[23] An interesting question in light of these findings is, "How much of the inverse relationship between COVID-19 deaths and nursing home quality is explained by higher-quality nursing homes avoiding staff and PPE shortages?" To answer this, we return to our baseline model, but add controls for shortages. In particular, among the nine staff and PPE measures, we calculate for each nursing home the number of shortages experienced between May 24th and September 13th of 2020 (e.g., if a home experienced a nursing shortage and an n95 mask shortage over this period, we would measure their total as 2). The results from this are in row 12 of Table 4. The results suggest that staff and PPE shortages can explain some of the quality gradient we report in Table 3. For example, in the basic model we estimate that five-star homes have 15.4 percent lower COVID-19 mortality than one-star homes. This number moves to 13.6 once we control for these shortages, meaning they can explain about 10 percent of the quality gradient.

[24] Testing data is only reported in the CMS data from August 16th through November 22nd of 2020.

[25] As nursing homes can only report such testing if a new positive case arises, we condition our analysis on facilities with a new positive case because higher-quality facilities have already been shown to have fewer positive cases.

Table 6
OLS/Maximum Likelihood where Outcomes are Different Measures of Nursing Home Quality.

Dependent variable		Sample mean	Coefficient (Standard error) on Overall starrating			
			2-star	3-star	4-star	5-star
A: Staff shortage (any 5/24/20 – 9/13/20)						
	Any nursing shortage?	0.378	−0.045	−0.068	−0.085	−0.107
			(0.011)	(0.014)	(0.016)	(0.014)
	Any aide shortage?	0.419	−0.050	−0.071	−0.093	−0.118
			(0.012)	(0.017)	(0.018)	(0.016)
	Any clinical staff shortage?	0.172	−0.021	−0.033	−0.032	−0.039
			(0.010)	(0.014)	(0.012)	(0.012)
B: PPE shortage (any 5/24/20 – 9/13/20)						
	N95 outage?	0.173	−0.009	−0.012	−0.027	−0.020
			(0.009)	(0.011)	(0.011)	(0.013)
	Surgical mask outage?	0.107	−0.003	−0.004	−0.009	−0.001
			(0.009)	(0.011)	(0.011)	(0.014)
	Eye protection outage?	0.111	0.009	0.008	−0.002	−0.001
			(0.008)	(0.010)	(0.011)	(0.012)
	Gown outage?	0.121	0.006	0.008	−0.007	0.000
			(0.008)	(0.010)	(0.009)	(0.013)
	Glove outage?	0.069	−0.012	−0.006	−0.020	−0.014
			(0.007)	(0.008)	(0.008)	(0.010)
	Hand sanitizer outage?	0.071	−0.016	−0.020	−0.028	−0.023
			(0.009)	(0.008)	(0.009)	(0.010)
C: Testing procedures (week ending 9/13/20)						
	Time to test	2.396	0.003	−0.061	−0.052	−0.103
			(0.064)	(0.089)	(0.062)	(0.072)
	Test asymptomatic residents after a new resident case?	0.509	0.067	0.018	0.087	0.045
			(0.026)	(0.029)	(0.033)	(0.029)
	Test asymptomatic staff after a new resident case?	0.445	0.070	0.033	0.068	0.060
			(0.024)	(0.028)	(0.028)	(0.026)
	Ever test non-exposed resident?	0.374	0.017	0.034	0.048	0.050
			(0.016)	(0.018)	(0.017)	(0.022)
	Ever test non-exposed staff?	0.642	0.001	−0.002	0.018	0.016
			(0.013)	(0.018)	(0.014)	(0.016)
	Have in-home testing machine?	0.669	0.006	0.010	0.018	−0.007
			(0.015)	(0.015)	(0.018)	(0.019)
D: Vaccinations, as of 6/20/21						
	Share of residents vaccinated	0.800	0.013	0.024	0.042	0.056
			(0.006)	(0.006)	(0.006)	(0.008)
	Share of staff vaccinated	0.567	0.022	0.039	0.066	0.083
			(0.007)	(0.008)	(0.009)	(0.009)

Standard errors allow for arbitrary correlation across observations within a state. Other controls in the models include logged total beds; percent of residents that are female, under 65, black, Hispanic, on Medicaid (along with corresponding indicators for missing variables); for-profit status; acuity index; county-level COVID-19 cases per 1000 residents (measured 23 days prior to death); logged county population; and a full set of state fixed effects. All models are estimated via OLS except "time to test", which is modeled as an ordered logit that is estimated via MLE.

III.C. Non-COVID and total mortality

In addition to PPE use, adequate staffing, and robust testing, an early prevention method used by virtually all nursing homes was to refuse all outside visitors. On March 13th, 2020, CMS issued memorandum QSO-20–14-NH recommending that all facilities nationwide "should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation" (CMS 2020a). The memorandum also advised cancelling "communal dining and all group activities, such as internal and external group activities." On May 18th, CMS issued memorandum QSO-20–30-NH, that provided a three-phase reopening plan for nursing homes (CMS, 2020d). The plan did not allow for outside visitors until a nursing home entered phase three, which (loosely) required (i) that COVID-19 cases in the outside community have declined for 14 consecutive days, (ii) no new cases within the nursing home for 28 days, (iii) no staff or PPE shortages, and (iv) homes have the capacity and supplies to test residents and staff weekly. In light of the continued spread of the virus and the strict reopening criteria, many nursing homes were still closed to visitors months later. Finally, on September 17th, 2020, CMS issued memorandum QSO-20–39-NH, that relaxed visitation guidelines, citing resident distress (CMS, 2020b). This memorandum was updated again on March 10th, 2021 in light of vaccine distribution.

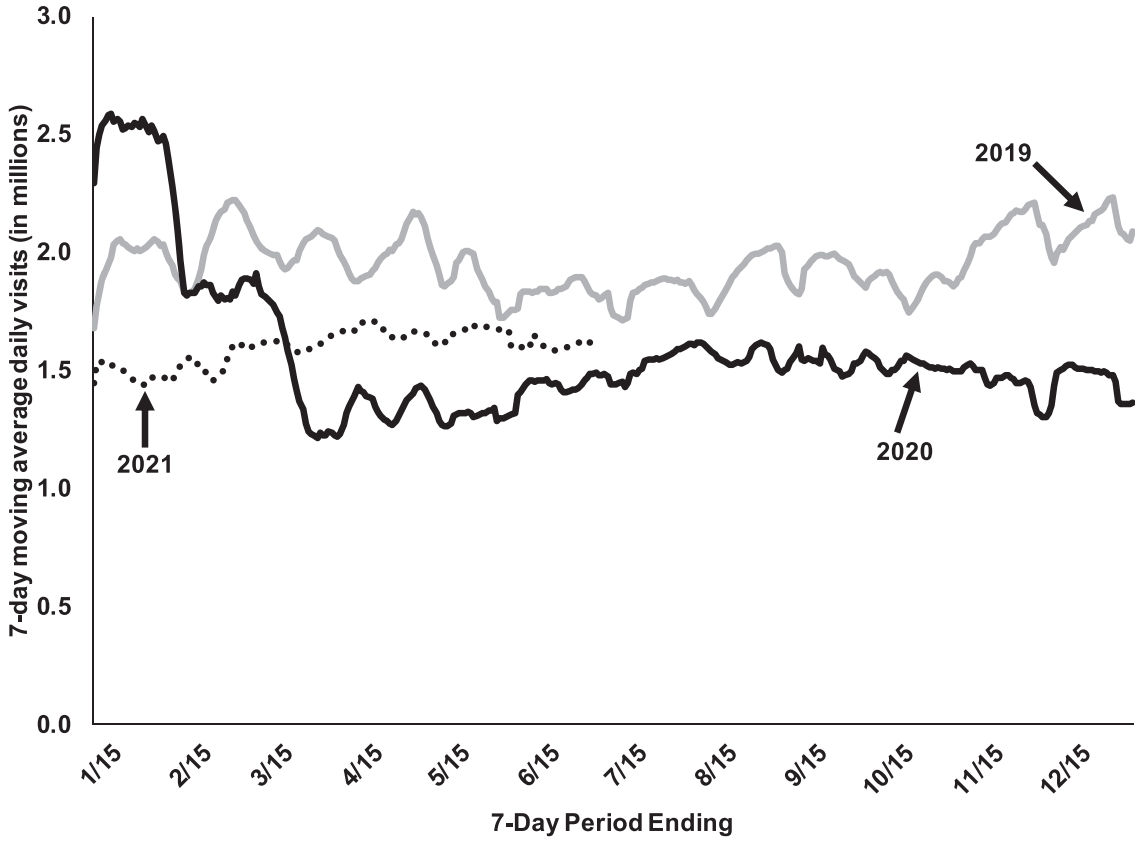

Fig. 2. Total Visits to US Nursing Homes by Calendar Day, Safegraph
This figure plots the total number of visitors to US nursing homes (NAICS code 623,110) by calendar-day, from the first of January 2019 through the end of June 2021. The data come from SafeGraph's Weekly Places Patterns data series, which uses cell phone location services to produce hourly counts of foot traffic to about 4 million points of interest in the US. The aggregate counts provided here are adjusted for the number of devices per person in the state, as is recommended by SafeGraph.

In Fig. 2, we use data from SafeGraph to document aggregate foot traffic to US nursing homes from the start of 2019 through mid-2021.[26] The figure shows (i) a large drop in nursing home foot-traffic in late January of 2020, approximately when the first COVID-19 case was discovered in the US and the World Health Organization (WHO) declared COVID-19 a global health emergency, followed by (ii) another drop in early March, when WHO declared COVID-19 a pandemic and President Trump declared a national emergency. Foot traffic rose slowly through August of 2020, but surprisingly, has remained mostly unchanged since then, despite several changes in the CMS visitation guidelines outlined above.

There may be some unfortunate downsides to these early policies that could have negatively impacted nursing home resident health. First, these policies may have generated extreme isolation among facility residents. A survey of nursing home residents from early fall of 2020 documents massive declines in resident interactions with outside visitors and fellow residents, trips off site, and even trips outside for fresh air (Montgomery et al., 2020). In the introduction, we noted that some observers caution that among individuals with Alzheimer's, isolation may be deadly. Second, without group meals or meals supervised by staff, residents may not have been eating as well. In their analysis of Connecticut nursing homes during the early stages of COVID, Levere et al. (2021) found a large decline in patient weight among residents, a change they attribute to the isolation caused by facility safety protocols. Third, the lack of communal activities may have reduced exercise and increased the time patients spent in bed. Levere et al. (2021) also found increases in bed sores among nursing home residents during the early stages of COVID. Fourth, a number of authors have documented large declines in medical care use, especially in the Medicare population, as a result of the COVID-19 pandemic (Bosworth et al., 2020; Ziedan et al., 2020; Cantor et al., 2020; Clemens et al., 2021). We suspect declines in medical care use were mostly generated by precautionary behavior on the part of residents and their families; even the most stringent stay-at-home orders provided exemptions

[26] The data are from the Weekly Places Patterns data series, which SafeGraph makes available free of charge to researchers. The files contain hourly counts of foot traffic to about 4 million points of interest in the US. Traffic is monitored using cell phone location services. Locations are organized by NAICS code; nursing homes are code 623110. The vertical axis contains aggregate counts, adjusted for devices per person in the state, as is recommended by SafeGraph.

for medical care. There could be some supply response if providers limited the types of visits or reduced hours. Within nursing homes, staff or residents themselves may have been less likely to travel off-site to visit a medical care provider.

Given the potential downsides of efforts to control the spread of the virus, we next examine whether high-quality nursing homes also managed the non-COVID risks created by isolation. In particular, we estimate Eq. (1) above, but with non-COVID deaths as our dependent variable. Like our analysis of COVID-19 deaths, we estimate effects across seven different time periods. The second panel of Table 3 (rows 8 through 14) contains parameter estimates. As of May 24th, 2020 (row 8), nursing home quality had no statistical effect on non-COVID deaths in nursing homes; however, by September 13th, 2020 (row 9), we document a large, positive, statistically significant impact of nursing home quality on non-COVID deaths. Five-star homes have about 11 percent more non-COVID deaths than one-star homes and deaths are increasing monotonically with quality. Rows 10 and 11 shows that the relationship between quality and cumulative non-COVID deaths has strengthened with time, as do rows 12 through 14, which look at non-COVID deaths occurring in early, middle, and more recent time intervals. That the relationship has strengthened with time is consistent with the narrative above. The longer patients are exposed to isolation from others and/or regular medical care is not received, the greater risk they face. Moreover, the patterns in Fig. 2 show that despite growing vaccination rates through early 2021, traffic in and out of nursing homes remained well below pre-pandemic levels. We repeat all robustness tests performed for COVID-19 deaths (reported in Table 4) for non-COVID deaths in Appendix Table A6, where non-COVID deaths are measured on September 13th, 2020. Results are robust to all tested specifications.

There is some concern that our findings can be explained by higher-quality nursing homes intentionally misreporting COVID-19 deaths as non-COVID deaths, potentially in an effort to protect their reputation. This concern is somewhat mitigated by Fig. 1. Were COVID-19 deaths consistently reported as non-COVID, we would expect stark rises in non-COVID deaths during the summer and winter waves of 2020; we see neither. Moreover, misreporting is most likely early in the pandemic and results using cumulative deaths as of September are nearly identical to those using deaths between May and September. Finally, the result is present in nursing homes even after COVID-19 vaccines were introduced and disease mortality fell to the lowest level in months.

Yet another alternative explanation of our findings is that COVID-19 "harvests" the most fragile residents from low-quality homes, meaning they are not around to die of non-COVID causes.[27] We address this concern, and further address the misreporting concern, by re-estimating Eq. (1) with *total* nursing home deaths as our dependent variable. We report parameter estimates in the third panel of Table 3 (rows 15 through 21). Our results show that there is not any period of time over which high-quality homes experienced fewer total deaths than low-quality ones, even very early in the pandemic (row 15) when statistically, high-quality homes were experiencing far fewer COVID-19 deaths (row 1).[28] By December 6th, 2020, high-quality homes had experienced statistically more total deaths than low-quality homes (row 17) and the gap between the two has grown over time (row 18). The last three rows of Table 3 show the urgency of the problem. From summer 2020 (row 19), to fall 2020 (row 20), and finally winter/spring 2021 (row 21), the positive relationship between nursing home quality and total deaths has increased in magnitude. In the latter of these three periods (row 21), five-star homes experienced 17.5 percent more total deaths than one-star homes. On a base of 11 deaths per home, this amounts to roughly two additional deaths in five-star homes over just a four-and-a-half-month period. By our estimates, all of these excess deaths are due to non-COVID causes.

A related concern to the one above is that due to patient churn in and out of nursing homes over time, the composition, and therefore underlying health, of residents may change. For example, it is plausible that fear of COVID-19 led the wealthiest, healthiest potential residents to avoid nursing homes. For this behavior to drive our findings – specifically, our finding that the relationship between quality and total deaths increases over time – it would need to be the case that the average resident at higher-quality homes became sicker, without a similar change occurring at lower-quality homes. Unfortunately, as we do not observe changes in average patient acuity within the home over time, we cannot test this theory. Alternatively, selection could lead higher-quality homes to have higher occupancy rates than lower-quality homes over time. Indeed, over the life of the surveillance data, occupancy rates at high 5-star homes go from three percentage points higher than 1-star homes to just under five percentage points higher. That said, when we control for the home's occupancy rate in our total death models, our results are very similar.[29]

In a final attempt validate the important role that visitation restrictions play in our findings, we look for empirical evidence that high-quality nursing homes allowed fewer visitors during the COVID-19 pandemic. To this end, we matched the individual nursing homes in our main data file to the foot traffic data in the SafeGraph point of interest series. Using zip-code and longitude/latitude coordinates in both data files, we were able to identify 12,300 homes with both foot traffic and nursing home quality data. Among

[27] To fix ideas, consider two nursing homes that differ only in overall quality. Each has ten fragile residents that, independent of COVID-19, would have died in 2020. Now, assume that five of the residents in the low-quality home die in early 2020 of COVID-19. In the data, we then observe ten non-COVID deaths in the high-quality home and just five such deaths in the low-quality home.

[28] In May and September of 2020 (rows 15 and 16), the relationship between nursing home quality and total deaths is positive, despite the fact that the impact of quality on COVID-19 deaths (rows 1 and 2) is larger in percentage terms than the impact of quality on non-COVID deaths (rows 8 and 9) in the same times periods. This peculiarity is explained by there simply being more non-COVID deaths than COVID-19 deaths. For example, consider September 13th, 2020. Row 2 suggests that five-star homes had (0.154*3.672) 0.565 fewer COVID-19 deaths than one-star homes. Row 9 suggests that five-star homes had (0.114*10.151) 1.157 more non-COVID deaths than one-star homes.

[29] For this analysis, we use the "occupied beds" variable the CMS data to calculate the average weekly occupancy rate in each nursing home between May 24th, 2020 and April 25th, 2021. We then control for the occupancy rate in our April 25th, 2021 total death regression (row 18 of Table 3). While the occupancy rate is positively associated with total deaths, the estimated quality effects are statistically indistinguishable from our main findings. (Results available upon request.) Note that we do not include the occupancy rate in all models because it is an imperfect (i.e., likely endogenous) control, as deaths in period t influence the occupancy rate in period t + 1.

these homes, we calculated average daily foot traffic (i) in January 2020 (i.e., pre-pandemic) and (ii) between January 1st, 2021 and April 25th, 2021. We then calculated the percent change from (i) to (ii). On average, foot traffic in nursing homes declined by 34 percent (s.d. 18). We then regress the percent decline in foot traffic on home quality, using a variety of specifications (e.g., including additional controls, state fixed effects, and county fixed effects, and with sample limitations for nursing home size and measurement error).[30]

We find that while quality is typically negatively associated with the change in foot traffic, the effects are never statistically different from zero; thus, we do not report results here, but they are available upon request. In addition to measurement error, the fact that SafeGraph does not distinguish between the cell phones of visitors, staff, and residents makes the foot traffic data an imperfect proxy for "number of visitors." This feature of the data poses a challenge to our validation exercise if, for example, high-quality homes experience a decline in visitors, while low-quality homes experience staff shortages (a reality that we document above.) Another concern is that the residents of high-quality homes are both younger and wealthier, meaning they and their visitors are more likely to possess cell phones. As SafeGraph expanded their network over the course of the pandemic, higher cell phone densities in higher-quality nursing homes could boost foot traffic counts, even as the number of visitors declined.

IV. Conclusion

The COVID-19 pandemic has ravaged residents of nursing homes with roughly one fifth of COVID-19 deaths coming from this group. Not surprisingly, the impact of the pandemic varied in some systematic ways across homes. Initially, higher-quality homes were much more successful at limiting the impact of the pandemic, primarily by preventing the spread of the disease once it entered the nursing home, but these differences declined over time. Between January of 2020 and April of 2021, cumulative COVID-19 mortality was lower in higher-quality nursing homes, all else equal; however, starting sometime in the Fall of 2020, the marginal death counts from COVID-19 were no different across nursing home of different quality levels. This finding suggests that higher-quality homes adapted quickly at the start of the pandemic, while lower-quality homes took more time to understand how to effectively contain the virus among residents.

Our results raise a new concern about higher-quality facilities, in that they have higher non-COVID mortality than lower-quality places. This finding is not due to a misclassification of deaths, as the relationship persists even after COVID-19 vaccines were introduced and COVID-19 mortality fell to a fraction of the levels seen at the height of the pandemic. It is also not due to harvesting – the notion that lower COVID-19 deaths in higher-quality homes might mean more residents are available to die from other causes – as higher-quality homes have higher aggregate mortality. A more troubling aspect of our findings is that as the home quality/COVID-19 mortality gradient was eliminated over time, the quality/non-COVID-19 mortality gradient has steadily increased as the pandemic has aged.

Our paper is less successful at identifying the reason for the quality/non-COVID mortality gradient. Our results indicate that higher-quality homes were better at following CMS guidelines designed to control the spread of the virus, such as having PPE equipment on hand, not having staff shortages, more frequent testing of both residents and staff, and having higher staff and resident vaccination rates. It is logical to assume then that higher-quality homes were also better at generating more distance between residents and the outside world by preventing building entry and isolating residents from one another. Anecdotal reports from doctors, nurses, and resident family members (Aronson, 2020; Paulin, 2020; Graham, 2020), as well survey data from residents themselves (Montgomery et al., 2020), document frightening levels of depression, loneliness, and hopelessness. Consistent with these reports, CMS updated their visitation guidelines in mid-September of 2020 to combat the mental and physical distress of isolation.[31] Analysis of the Minimum Data Set by Levere et al. (2021) during the early stages of the pandemic suggests that nursing home residents declined in health along dimensions consistent with increased isolation, such as unexplained weight loss, declines in cognitive function, and increases in depressive symptoms. This is, however, not the only pathway by which the pandemic could have altered non-COVID mortality. Isolation policies may coincide with, or even cause, reductions in routine medical care, residents' physical activity, or food consumption. The rise in bed sores and drop in weight found in Levere et al. (2021) suggest these other mechanisms may play a role.

The good news from Fig. 1 is that once vaccines became available, mortality declined considerably. Weekly deaths of nursing home residents with COVID-19 peak at 6082 the week ending December 20th, 2020. By the week ending May 21st, 2021, this number was 179, a 97 percent drop. Fig. 1 provides some hope that things might be returning to normal within these group quarters. Despite this positive trend, not all has returned to normal. The decline in visits to nursing homes in the early stages of the pandemic as measured by cell phone movements was dramatic. By April 1st of 2020, visits to nursing homes were down 51 percent compared to January of 2020. As vaccines became available and COVID-19 deaths in nursing homes fell considerably in early 2021, visits to nursing homes

[30] SafeGraph does not track the universe of cell phones; thus, the point of interest data can be sparse when facilities are small or located in rural environment. Among the 12,300 matched homes, over a thousand have zero visitors on more than a third of the days over our time-horizon. Thus, some of our specifications remove these 1000 homes with a high frequency of zero visitors, while others look only at homes with 100+ total beds. Both specifications remove measurement error, thereby improving the precision of our estimates.

[31] In a memo released September 17th outlining revised procedures for nursing homes during the pandemic, CMS notes that "…we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting" (CMS, 2020b). In this memo, CMS outlines policies for outdoor visitation and relaxed policies for indoor visitation in lower-risk settings such as counties with low positivity rates in the general population.

increased but never returned to anywhere near pre-pandemic levels. By the end of June 2021, visits were still down by 35 percent compared to the January 2020 levels. These numbers are imperfect measures of visits because they include counts of family and friends visiting residents plus, entrances by workers, traveling nurses and aids such as physical therapists, etc. It is also not clear whether the persistent decline in visits to nursing homes is supply driven (continue restrictions on the part of nursing homes) or demand driven (friends and family do not want to visit the nursing homes). Despite these caveats, the fact that foot traffic in nursing homes never returns to anywhere near normal levels could explain another feature of our findings – that the impact of higher-quality homes on non-COVID mortality continues to grow with time.

The COVID-19 pandemic presented a unique challenge for nursing homes. Early CMS directives and various state regulations for nursing homes prioritized reducing resident and staff exposure to COVID-19. There was little discussion about the downside risks associated with reducing visitors, communal activities, and resident travel out of the home. Our results suggest that more balanced policies and guidelines that emphasize maximizing the health of residents, rather than just minimizing risk to one disease, may have improved outcomes. For a period of time, CMS and the news media at large measured nursing home COVID-19 performance using cases and deaths only, meaning the logical response on the part of the nursing home was to minimize these counts regardless of the cost. In retrospect, the tone of the discussion and the measurement of outcomes may have led to some deadly consequences. As economists continually stresses, there are benefits and costs to all regulations.

Author statement

This is the author statement for the paper referenced above. The two authors of this paper were engaged in all aspects of the production of this manuscript including: Conceptualization; methodology; software; validation; formal analysis; investigation; resources; data curation; writing;, visualization; supervision; project administration; and funding acquisition.

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Appendix A. Preparation of the estimation sample

We downloaded the CMS Covid-19 Nursing Home data file on August 2nd, 2021, which contains information reported through the week of July 18th, 2021; 61 weeks total. Our analysis is limited to the weeks ending May 24th, 2020 through May 9th, 2021; 51 weeks. Over this time-frame, 15,421 homes report data to CMS in at least one week. Squaring the data produces 786,471 home-week observations. Roughly 10 percent of these observations are missing or are flagged by CMS for poor quality (henceforth, "problem" observations); however, a small minority of homes account for most of the errors. We drop all homes with more than ten problem observations; 15,110 homes and 770,610 observations remain, which includes just 4574 problem observations (0.59 percent of all observations), 28 percent of which are in the first two weeks of reporting.

Cumulative death counts are calculated by CMS from weekly death reports; thus, any problem observations create measurement error in all cumulative counts moving forward. As such, we impute weekly death counts for all problem observations and recalculate the cumulative counts using the procedure that follows. **Step 1**: For the weeks ending May 2nd and May 9th of 2021 (not used in any regression analysis in the paper), we regress weekly COVID-19 deaths and weekly non-COVID deaths on new county COVID-19 cases and the number of beds, as well as quadratics of these variables, for all non-problem observations. We then use the regression coefficients to predict weekly COVID and non-COVID deaths for problem observations in these weeks. **Step 2**: Starting with the week ending April 25th, 2021 (the last week used in regression analysis in the paper), we predict weekly COVID (non-COVID) deaths for problem observations using new county COVID cases and the number of beds, as well as quadratics of these variables, *and* COVID (non-COVID) deaths over the following two weeks at the nursing home. **Step 3**: repeats step 2 recursively for the weeks ending April 18th, 2021 through May 24th, 2020.[32]

Finally, note that among the 15,110 homes that comprise our final CMS sample (e.g., see summary statistics in Appendix Table A3), 205 homes cannot be matched to a home in the star-quality data, which explains the sample size of 14,905 in our main regression analysis.

[32] Note that step 1 guarantees that COVID and non-COVID deaths are non-missing regressors in step 2. Furthermore, by imputing backwards, we guarantee that these regressors are non-missing in every week. Finally, note that the imputation takes place week-by-week to account for (i) various COVID-19 waves that have occurred over time and (ii) the fact that some homes report cumulative cases, while others report weekly cases in the first week of reporting, May 24th, 2020.

Table A1
Comparing State and CMS Reports of COVID-19 Deaths in Nursing Homes for 37 States.

Source	Deaths as of 5/24/2020 (a)	Deaths as of 3/7/2021 (b)	Δ deaths (b) – (a)
CMS (1)	21,189	104,374	83,185
State facility reports (2)	24,286	110,254	85,968
Difference (2) – (1)	3079	5880	2783
% difference (2) – (1)	14.5%	5.6%	3.3%

Calculations made for the 37 US states reporting COVID-19 deaths among nursing home residents on state dashboards. State facility reports refer to the death counts from these dashboards, while CMS refers to the deaths counts in the CMS COVID-19 surveillance data discussed in Section II.A.

B. Data quality check

To validate aggregate death counts in the CMS nursing home data, we compared it to data compiled by the COVID-19 Tracking Project (CTP), a web page maintained by the Atlantic.[33] The authors of the web page aggregate weekly data on COVID-19 deaths among nursing home residents using state COVID-19 dashboards, private correspondences with states, and state press conferences. For many states, the CTP has data by individual facility. In these cases, we aggregated data by week up to the state level. Some states report weekly totals separated by sector (e.g., nursing homes, assisted living, etc.) while other states aggregate these sectors together making the data not comparable to the CMS statistics. Dropping states that either do not report nursing home deaths, do not distinguish between nursing homes and other senior living facilities like assisted living, or do not report until after the first CMS weekly report on March 24th, 2020, we can generate consistent data from the two sources for 37 states. The CTP stopped collecting this data by March 7th, 2021.

In Table A1, we report in the first column aggregate deaths in the first CMS nursing home report for the week ending May 24th, 2020, plus data from the CTP for the 37-state sample. The CMS data under-reports death counts by 14.5% for this first report. This is due to two potential limitations of the CMS data. First, some nursing homes did not report that first week. We believe this is a small component of the problem as mortality data is reported for 98% of nursing homes that week. Second, at the time of the first CMS report (May 24th), CMS allowed nursing homes the choice to report cases and deaths from the prior week *or* cumulative cases and deaths since January 1st. Thereafter, homes report weekly counts and a cumulative count is calculated by CMS; thus, if a home fails to report the cumulative count since January 1st on May 24th, the cumulative count that CMS calculates in future weeks is incorrect. In the second column of Table A1, we report cumulative COVID-19 deaths through the last week of data in the CTP and in the final column, we compare the difference between the last and first dates. The fraction undercount in the CMS data is only 5.6 percent in early March 2021, and the difference in counts between these two dates is only 3.3 percent. These results suggest that the major under-reporting in the CMS data is occurring in the first week, but that cumulative counts after the first week are more comparable to what nursing homes are reporting to states.

This is visually verified in Fig. A1 where we plot on the horizontal axis the nursing home death counts as of March 24th, 2020 in the CTP data, while the vertical axis has the comparable data from the CMS data for our 37-state sample. There are a noticeable number of points that fall below the 45-degree line, indicating CMS undercounts relative to CTP (i.e., state reports) at that time.

In Fig. A2, we re-do Fig. A1 but use the difference in counts between March 2021 and May 2020 as the outcome of interest. Here there is a much more even spread of points around the 45- degree line.

These numbers suggest that to accurately assess the cumulative impact of COVID-19 mortality in nursing homes, we need to inflate the first week's numbers then recalculate cumulative deaths after that point. In Table A2, we calculate cumulative deaths as of August 15th, 2021 by inflating the first CMS report by 14.5%, then adding to this the cumulative deaths reported to CMS between the first report and August 15th, 2021. Using this method, we estimate that there were 137,318 COVID-19 deaths among nursing home residents as of August 15th, 2021. At that point in time, there were 634,179 COVID-19 deaths in total in the US, meaning that 21.7% of COVID-19 deaths were to nursing home residents.

C. CMS star quality ratings

The nursing home star ratings come from data.medicare.gov. There are three separate ratings – inspection, quality measures (QM), and staffing – which are aggregated by CMS into an overall rating. All three ratings, as well as the overall rating, measure quality in integer "star" values, where five-star is the best possible rating and one-star is the worst.

The inspection rating is based on results from the home's three most recent state health inspections in a three-year period, with more weight given to the most recent inspections, as well as investigations stemming from formal complaints. The ratings used in

[33] https://covidtracking.com/nursing-homes-long-term-care-facilities/data-by-state

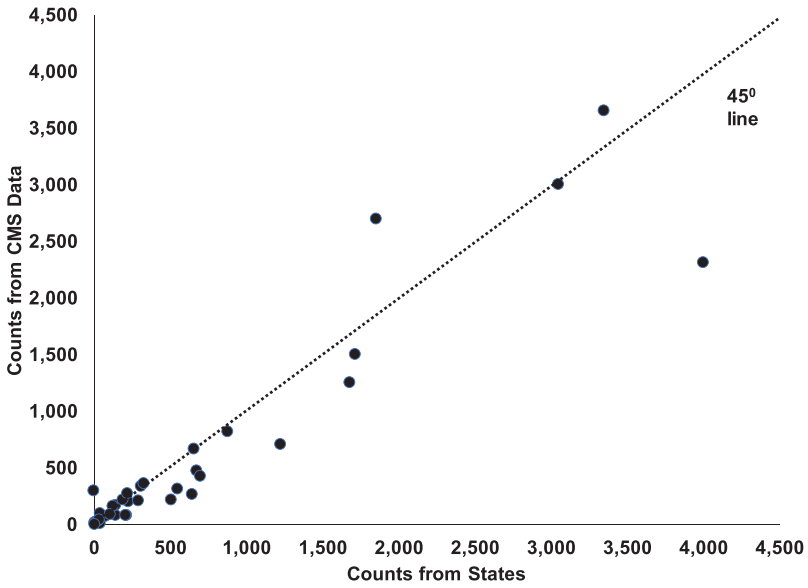

Fig. A1. Scatter Plot, State and CMS Reports of COVID-19 Deaths in Nursing Homes for 37 States, As of 5/24/2020
Observations are the 37 US states reporting COVID-19 deaths among nursing home residents on state dashboards. The horizontal axis measures death counts from these dashboards, while the vertical axis measures deaths counts in the CMS COVID-19 surveillance data discussed in Section II.A.

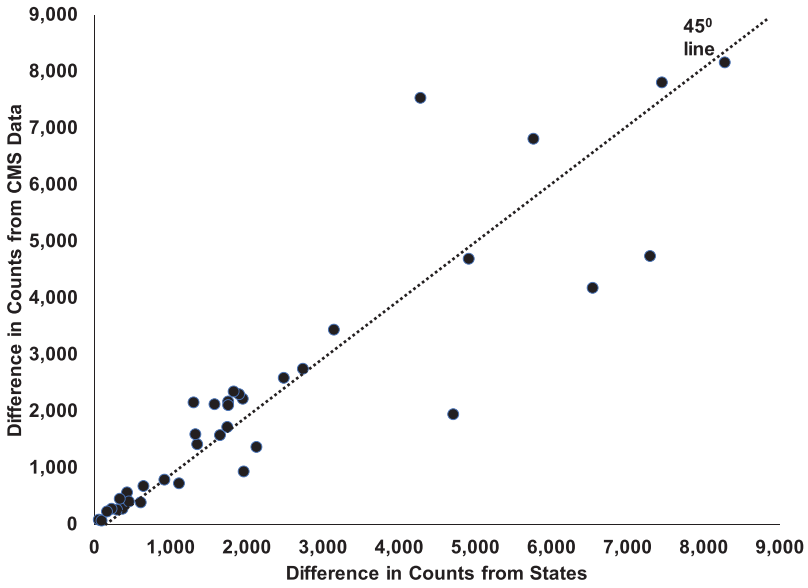

Fig. A2. Scatter Plot, State and CMS Reports of COVID-19 Deaths in Nursing Homes for 37 States, Difference between 3/7/2021 and 5/24/2020
Observations are the 37 US states reporting COVID-19 deaths among nursing home residents on state dashboards. The horizontal axis measures death counts from these dashboards, while the vertical axis measures deaths counts in the CMS COVID-19 surveillance data discussed in Section II.A.

our analysis were first reported by CMS in June of 2020 and we can verify in the data that the latest inspections informing the rating took place in February of 2020, before the start of the pandemic. The QM rating is based on a home's self-reported ability to manage and prevent certain negative health outcomes (e.g., bedsores, ED visits, chronic pain, major injuries resulting from falls, urinary tract infections, etc.). The staff rating is a function of the reported number of registered nurses and total staffing hours relative to the number of residents.

As the inspection rating is the only measure calculated from data that is not self-reported, it is viewed as the most objective and, thus, is given greater weight in the calculation of the overall star rating (Williams et al., 2010). The rating system has been criticized by many, especially the QM and staff rankings portions. Exposés by the New York Times at various points in time (e.g., Thomas, 2014; Silvger-Greenberg and Gebeloff, 2021) demonstrate that for many nursing homes, the self-reported data is at best

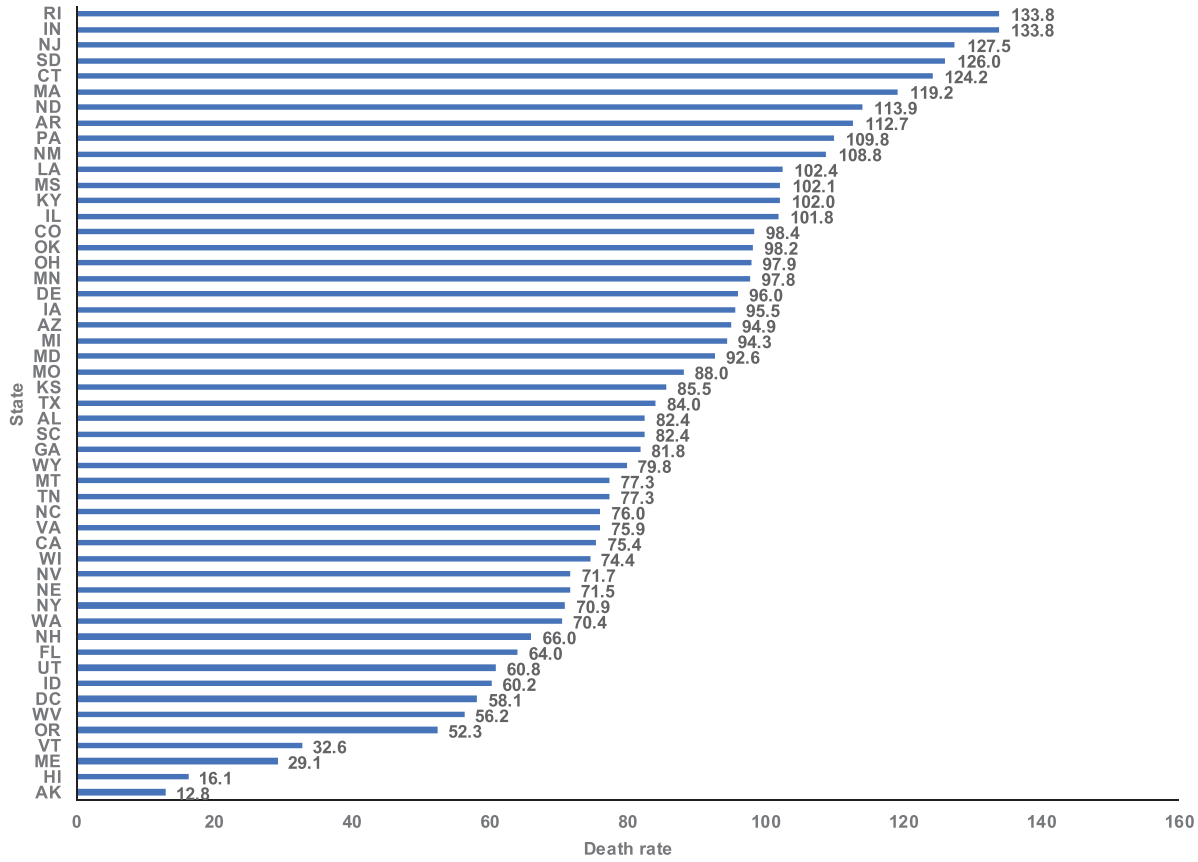

Fig. A3. COVID-19 Deaths Rates (deaths/1000) in Nursing Homes, as of End of 2020
Information taken from CMS COVID-19 surveillance data discussed in Section II.A.

Table A2
National Estimates of COVID-19 Deaths in Nursing Homes from Inflated CMS Data,As of 8/15/2021.

Number	Death Count
(1) National estimates as of 5/24/2020	25,354
(2) Inflate by 14.5%	29,030
(3) Change between 8/15/2021 and 5/24/2020	108,288
(4) total (3) + (2)	137,318

Row 1 measures death counts among nursing home residents in all 50 states as reported in the CMS COVID-19 surveillance data discussed in Section II.A. Row 2 inflates this figure by the estimated 5/24/2020 undercount calculated in Table A1. Row 4 adds to this figure deaths reported to CMS after 5/24/2020 (Row 3) which we've show are more accurately reported.

incomplete and at worst fraudulent. Looking at the QM data, Sanghavi et al. (2019) document that only 57% of nursing home falls are reported to CMS. Comparing Medicare claims for inpatient services with data reported to CMS for the five-star ranking, Integra Med Analytics (2021) found little correlation for hospital claims based measured of quality and what is reported in the five-star data for urinary tract infections, falls, and bed sores. Numerous authors have shown that the inspection rating is predictive of better health outcomes among residents (Fuller et al., 2019; Perraillon et al., 2017), but the strength of the relationship is in question for some scales. In one of the largest studies to date, Neuman et al. (2014) found the inspection rating predicted hospital readmissions for people discharged to a nursing home but the staff rating did not.

Surveys suggest that the rating system is correlated with family and resident satisfaction with care (Çalikoglu et al., 2011), but that the inspection rating seems to be most correlated with these measures of satisfaction (Williams et al., 2016).

Table A3
Sample Characteristics, CMS Data on Nursing Homes, as of September 13th, 2020.

Variable	Mean	S.D.
Total beds	106.222	58.858
Share of female residents	0.663	0.119
Share of female residents, missing	0.086	0.280
Share of residents under 65 years old	0.226	0.177
Share of residents under 65 years old, missing	0.547	0.498
Share of black residents	0.165	0.220
Share of black residents, missing	0.446	0.497
Share of hispanic residents	0.049	0.134
Share of black residents, missing	0.421	0.494
Share of residents on Medicaid	0.599	0.230
For profit	0.702	0.457
Acuity index	12.189	1.479
Medicaid, profit, and acuity missing	0.062	0.242
Observations	15,110	

The construction of this sample is discussed in Appendix Section A. Total beds is measured using the CMS COVID-19 surveillance data discussed in Section II.A. All other variables come from the LTC Focus database at Brown University.

Table A4
Distribution of Inspection Ratings in CMS Nursing Home Data.

Star rating	Overall rating	Inspection rating	QM rating	Staff rating
1	0.151	0.193	0.049	0.075
2	0.193	0.236	0.126	0.247
3	0.178	0.224	0.196	0.276
4	0.213	0.233	0.251	0.215
5	0.252	0.102	0.363	0.114
missing	0.014	0.014	0.014	0.074
Observations	15,110			

Sample construction is discussed in Appendix Section A. Star ratings are taken from the CMS website.

Table A5
Correlation if the Inspection Ratings in CMS Nursing Home Data.

Star rating	Overall rating	Inspection rating	QM rating	Staff rating
Overall rating	1.000			
Inspection rating	0.860	1.000		
QM Rating	0.504	0.233	1.000	
Staff rating	0.478	0.221	0.212	1.000

Sample construction is discussed in Appendix Section A. Star ratings are taken from the CMS website.

The rating distributions across homes in our sample can be found in Appendix Table A4 below. In Appendix Table A5 we report the correlation coefficients across nursing homes for the four measures. It is not surprising that the overall quality and the inspection scale are the most correlated since the latter is weighted most heavily when calculating the former. The level of correlation between the inspection rating and QM and staff ratings is very low; the latter two ratings are also not highly correlated with one another.

Table A6
Robustness Analysis, non-COVID deaths measured 9/13/2020 unless stated otherwise.

			Overall star rating			
Model	Sample Mean	Obs	2-star	3-star	4-star	5-star
(1) Baseline (Table 3, row 9)	10.15	14,905	0.034	0.070	0.088	0.114
			(0.029)	(0.031)	(0.034)	(0.041)
(2) Model (1), but Poisson	10.15	14,905	0.045	0.051	0.043	0.059
			(0.052)	(0.085)	(0.072)	(0.057)
(3) Model (1) but OLS with ln(deaths+1)	8.84	11,532	0.033	0.091	0.118	0.123
			(0.038)	(0.038)	(0.042)	(0.053)
(4) Model (3) but add county FE	1.84	14,905	0.041	0.073	0.099	0.127
			(0.034)	(0.034)	(0.036)	(0.047)
(5) Model (1) but OLS with inverse hyperbolic sine of deaths	1.84	14,905	0.069	0.071	0.127	0.159
			(0.046)	(0.046)	(0.049)	(0.064)
(6) Model (5) but add county FE	2.29	14,905	0.047	0.089	0.117	0.148
			(0.041)	(0.040)	(0.044)	(0.056)
(7) Model (1) but OLS with inverse hyperbolic sine of death rate (per 100 beds)	2.29	14,905	0.080	0.088	0.151	0.186
			(0.055)	(0.055)	(0.059)	(0.077)
(8) Model (7) but add county FE	2.29	14,905	0.047	0.089	0.117	0.148
			(0.041)	(0.040)	(0.044)	(0.056)
(9) Model (1) but add controls for staff hours per resident day	2.29	14,905	0.080	0.088	0.151	0.186
			(0.055)	(0.055)	(0.059)	(0.077)
(10) Model (1) but add controls for republican share of county	10.15	14,558	0.031	0.064	0.081	0.112
			(0.030)	(0.033)	(0.035)	(0.042)
(11) Model (1) but add controls for any staff and resident cases, as well as counts	10.15	14,888	0.033	0.071	0.090	0.118
			(0.029)	(0.031)	(0.034)	(0.041)
(12) Model (1) but add controls for shortage counts	10.15	14,905	0.032	0.072	0.087	0.112
			(0.029)	(0.031)	(0.034)	(0.039)

Standard errors allow for arbitrary correlation across observations within a state. Other controls in the models include logged total beds; percent of residents that are female, under 65, black, Hispanic, on Medicaid (along with corresponding indicators for missing variables); for-profit status; acuity index; county-level COVID-19 cases per 1000 residents (measured 23 days prior to death); logged county population; and a full set of state fixed effects.

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Exhibit K

COVID-19 DC BUREAU HEALTH CARE HEALTH POLICY SAFETY NET STATE GOVERNMENT

Whitmer, Cuomo push back on DOJ's 'political' nursing home COVID-19 inquiry

BY: **KEN COLEMAN** - AUGUST 27, 2020 6:51 AM

New York Gov. Andrew Cuomo speaks to the media at the Javits Convention Center which is being turned into a hospital to help fight coronavirus cases on March 24, 2020 in New York City. | Eduardo Munoz Alvarez/Getty Images

The U.S. Department of Justice (DOJ) Wednesday requested that Gov. Gretchen Whitmer and three other states led by Democrats submit data related to nursing homes and COVID-19 deaths.

In a joint statement with New York Gov. Andrew Cuomo, the governors suggest the action is a politically motivated hit from the President Trump administration.

"This is nothing more than a transparent politicization of the Department of Justice in the middle of the Republican National

Convention," the statement reads. "It's no coincidence the moment the Trump administration is caught weakening the [Centers for Disease Control] COVID-19 testing guidelines to artificially lower the number of positive cases, they launched this nakedly partisan deflection. At least 14 states – including Kentucky, Utah and Arizona – have issued similar nursing home guidance all based on federal guidelines – and yet the four states listed in the DOJ's request have a Democratic governor."

The DOJ, through a news release, stated that four states – New York, New Jersey, Pennsylvania, and Michigan – all "required nursing homes to admit COVID-19 patients to their vulnerable populations, often without adequate testing," something Republicans in the Legislature have frequently claimed and the Whitmer administration has denied.

"The Department of Justice's Civil Rights Division is evaluating whether to initiate investigations under the federal 'Civil Rights of Institutionalized Persons Act', which protects the civil rights of persons in state-run nursing homes, among others," the DOJ statement reads. "The Civil Rights Division seeks to determine if the state orders requiring admission of COVID-19 patients to nursing homes is responsible for the deaths of nursing home residents."

Michigan ranks 13th in the nation and the District of Columbia in the number of nursing homes deaths, according to the U.S. Centers for Disease Control's National Healthcare Safety Network. New Jersey; Massachusetts; Connecticut; Rhode Island; Delaware; Washington, D.C.; Pennsylvania; Maryland; Mississippi, Arizona, Louisiana; and New York rank ahead of Michigan.

Michigan Department of Health and Human Services Director Robert Gordon in June issued an order regarding long-term care facilities. It required regular testing and timely and accurate reporting of cases, deaths, distribution of personal protective equipment and a plan to address staffing shortages.

"We're doing everything in our power to protect nursing facility residents through mandatory testing, support for adequate staffing, and new efforts at infection control," Gordon said at the time.

In June, Attorney General Dana Nessel rejected federal GOP lawmakers' request to investigate Whitmer's executive order regarding COVID-19 impacts in nursing homes.

"While I appreciate and share your concern for the impact of COVID-19 on the health and safety of our elderly population, I am curious as to why similar requests have not been sent to states with Republican Governors," Nessel wrote in a letter to the the U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis.

At the time, similar requests were sent to the attorneys general of states led by Democratic governors, including New York, New Jersey, California and Pennsylvania.

Nessel, a Democrat, noted she's investigated members of her own party, including the Whitmer administration for a now-terminated COVID-19 contact-tracing contract, but "unlike our current USAG,

I will not utilize my prosecutorial authority for political ends- neither to pursue my enemies nor to protect my friends," Nessel wrote on Twitter, in an apparent dig of U.S. Attorney Matthew Schneider, who was tapped by U.S. Attorney General Bill Barr to probe Whitmer's coronavirus emergency actions.

The GOP-led Legislature has convened a special bipartisan panel to investigate the Whitmer administration's COVID-19 response and has held several hearings on nursing homes.

KEN COLEMAN

Ken Coleman writes about Southeast Michigan, history and civil rights. He is a former Michigan Chronicle senior editor and served as the American Black Journal segment host on Detroit Public Television. He has written and published four books on Black life in Detroit.

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Exhibit L

Congress of the United States
Washington, DC 20515

September 23, 2020

The Honorable Eric Dreiband
Assistant Attorney General
Civil Rights Division
United States Department of Justice
950 Pennsylvania Ave. NW
Washington, DC 20530

Dear Assistant Attorney General Dreiband,

We write regarding the Department of Justice's (DOJ) request for data from public nursing homes in New Jersey, New York, Michigan, and Pennsylvania. While there is no question that every state and the federal government must protect residents of long-term care facilities (LTCs), we believe the DOJ's investigation may be politically driven and ultimately does not protect any LTC residents.

Our country requires a thorough examination of every state LTC and the policies that each state utilizes to protect LTC residents. However, the DOJ has very little jurisdiction over LTCs through the Civil Rights of Institutionalized Persons Act (CRIPA). CRIPA limits the DOJ's investigation to institutions "providing skilled nursing, intermediate or long-term care, or custodial or residential care" that are "owned, operated, or managed by, or provide services on behalf of" a state "or a political subdivision of" a state.[1] Public nursing homes make up fewer than three percent of LTCs in New Jersey, fewer than five percent in New York, fewer than four percent in Pennsylvania, and approximately seven percent in Michigan.[2] The vast majority of LTC residents in these states and elsewhere live in privately-owned facilities, which makes us question why the administration is targeting public nursing homes, let alone those public nursing homes in these four states.

Under the pretense of protecting LTC residents, DOJ has requested information from these four states as they seek to "determine if the state orders requiring admission of COVID-19 patients to nursing homes is responsible for the deaths of nursing home residents." However, New Jersey, New York, Michigan, and Pennsylvania were not the only states to implement orders on admission policies, nor should this be the sole factor examined to determine what policies were responsible for the tragic loss of life experienced within LTCs. At least 14 states — including Kentucky, Utah, and Arizona — have issued similar nursing home guidance all based on federal guidelines – and yet the four states listed in the DOJ's request have a Democratic governor. We question DOJ's targeting of these four states instead of all the states that modeled guidance on Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC).

While LTC residents are particularly vulnerable to COVID-19 and other infectious diseases, the Trump administration was actively rolling back many of the protections and rights of LTC residents, further exacerbating existing gaps and deficiencies that went unaddressed in LTCs. Since 2017, CMS has worked to reduce standards in LTCs including infection control, facility assessments, and transfers and discharges through rulemaking. Under the pretense of "reducing burden" on LTCs, CMS has made changes that disregard the health and safety of residents in favor of reducing accountability and enforcement.[3]

Even amid the pandemic, the Trump administration has continued to push these rollbacks forward, including the egregious proposal to no longer require LTCs to employ infection prevention specialists at least part-time. More than 80 percent of LTCs were cited with infection control deficiencies, the most commonly cited deficiency, in one or more years between 2013 and 2017.[4] While the Trump administration's defense of proposals that have the potential to cause serious harm to residents of LTCs during a global pandemic is abhorrent, investigating LTCs under the guise of enforcing CRIPA is clearly a double standard.

Additionally, the majority of the data that DOJ is requesting is not only public and updated daily on each state's COVID-19 webpages, it is also public and updated weekly by CMS through its COVID-19 Nursing Home Dataset.[5] Furthermore, all state-issued guidance regarding LTCs and admission to public nursing homes is available on each state's webpage.[6] It appears that the DOJ is solely issuing these letters to states to make a political point. In fact, during the entire Trump administration up until 2020, DOJ has only opened eleven CRIPA investigations in total, none of which were for public nursing homes.

In light of this history, please answer the following questions:

1. Has DOJ sent similar letters to any other states, not including its investigation into the Massachusetts State Veterans Home, regarding a COVID-19 related investigation into public nursing homes?

2. Does DOJ plan to send similar letters to states that are still experiencing an increase in COVID-19 cases and deaths in public nursing homes?

3. Has DOJ opened any other COVID-19 related CRIPA investigations into any jails or prisons, juvenile correctional facilities, public nursing homes, or mental health facilities and institutions for individuals with intellectual disabilities?

4. DOJ has the authority under CRIPA to investigate all jails and prisons, which have more than 100,000 positive COVID-19 cases and at least 900 deaths.[7] Why hasn't DOJ opened a CRIPA investigation into jails and prisons with COVID-19 cases and deaths?

5. Has DOJ worked with CMS, the agency with jurisdiction over LTCs that participate in Medicare, to understand the broader policy failures on both the state and federal level that contributed to the vast loss of life in LTCs due to COVID-19?

6. Will the administration pursue an independent investigation into federal and state policies that contributed to COVID-19 cases and deaths in LTCs?

While we do not deny that the federal government must protect residents of LTCs and any institutionalized individual, this action by DOJ does not actually protect those individuals. Instead, it appears DOJ is abusing its power by taking aim at states that have criticized President Trump's actions during the COVID-19 pandemic, continuing a pattern of unprecedented politicization of the DOJ's activities since 2017. Therefore, we call on the DOJ to chart a different course of action and pursue a comprehensive independent investigation into failed policies that left so many Americans in LTCs vulnerable to COVID-19.

Sincerely,

Bill Pascrell, Jr.
Member of Congress

Brendan F. Boyle
Member of Congress

Daniel T. Kildee
Member of Congress

Paul D. Tonko
Member of Congress

/s/
Nydia M. Velázquez
Member of Congress

/s/
Jerrold Nadler
Member of Congress

/s/
Tom Malinowski
Member of Congress

/s/
Brenda L. Lawrence
Member of Congress

/s/
Dwight Evans
Member of Congress

/s/
Andy Levin
Member of Congress

/s/
Yvette D. Clarke
Member of Congress

/s/
Bonnie Watson Coleman
Member of Congress

/s/
Debbie Dingell
Member of Congress

/s/
Donald Norcross
Member of Congress

/s/
Adriano Espaillat
Member of Congress

/s/
Matthew Cartwright
Member of Congress

/s/
Albio Sires
Member of Congress

/s/
Eliot L. Engel
Member of Congress

/s/
Madeleine Dean
Member of Congress

/s/
Mary Gay Scanlon
Member of Congress

/s/
Donald M. Payne, Jr.
Member of Congress

/s/
Grace Meng
Member of Congress

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Exhibit M

New York State Office of the Attorney General Letitia James

Nursing Home Response to COVID-19 Pandemic

Revised January 30, 2021

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Executive Summary

This report is based on preliminary findings of the Office of Attorney General Letitia James (OAG)[1] from a review of information available through November 16, 2020. The report includes facts from the OAG's preliminary investigations of allegations of COVID-19-related neglect of nursing home residents across New York state and health data maintained as a matter of law by nursing homes and the New York State Department of Health (DOH).

In early March,[2] OAG received and began to investigate allegations of COVID-19-related neglect of residents in nursing homes. On April 23, OAG set up a hotline to receive complaints relating to communications by nursing homes with family members prohibited from in-person visits to nursing homes.[3] OAG received 774 complaints on the hotline through August 3 (an additional 179 complaints were received through November 16). OAG also continued to receive allegations of COVID-19-related neglect of residents through pre-existing reporting systems. During this time, OAG received complaints regarding nursing homes across the state, with a greater volume of complaints regarding nursing homes in geographic areas with higher rates of community-based transmission of COVID-19.

OAG is conducting ongoing investigations into more than 20 nursing homes across the state whose reported conduct during the first wave of the pandemic presented particular concern. Other law enforcement agencies also have ongoing investigations relating to nursing homes. Under normal circumstances, OAG would issue a report with findings and recommendations after its investigations and enforcement activities are completed. However, circumstances are far from normal. DOH data reports over 6,645 resident deaths as of November 16, with the vast majority (over 6,420) of those deaths occurring as of August 3. The COVID-19 health crisis is continuing and projected to worsen in the coming winter months. Infection rates are rising across the state, and across states nationwide, following increased travel and social gatherings over the holiday season. Inconsistent public compliance with face mask wearing, social distancing, and hand washing persists — despite orders and scientific guidance that shows these practices reduce the risk of COVID-19. Under these circumstances, nursing home residents remain especially vulnerable to transmission of COVID-19.

Attorney General James is issuing this report including findings based on data obtained in investigations conducted to date, recommendations that are based on those findings, related findings in pre-pandemic investigations of nursing homes in New York, and other available data and analysis thereof. Attorney General James offers this information to the public in the interest of increasing transparency and awareness and encouraging collective action by our state's residents to protect each other and our state's vulnerable nursing home residents. In addition, this information may be useful to other decision-makers for their consideration as they continue to respond to the ongoing pandemic.

OAG's preliminary findings are:

» A larger number of nursing home residents died from COVID-19 than DOH data reflected.

» Lack of compliance with infection control protocols put residents at increased risk of harm during the COVID-19 pandemic in some facilities.

» Nursing homes that entered the pandemic with low U.S. Centers for Medicaid and Medicare Services (CMS) Staffing ratings[4] had higher COVID-19 fatality rates than facilities with higher CMS Staffing ratings.

» Insufficient personal protective equipment (PPE) for nursing home staff put residents at increased risk of harm during the COVID-19 pandemic in some facilities.

» Insufficient COVID-19 testing for residents and staff in the early stages of the pandemic put residents at increased risk of harm in some facilities.

» The current state reimbursement model for nursing homes gives a financial incentive to owners of for-profit nursing homes to transfer funds to related parties (ultimately increasing their own profit) instead of investing in higher levels of staffing and PPE.

» Lack of nursing home compliance with the executive order requiring communication with family members caused avoidable pain and distress; and,

» Government 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.

To address the report's findings, a summary of recommendations follows below.

Recommendations:

» Ensure public reporting by each nursing home as to the number of COVID-19 deaths of residents occurring at the facility — and those that occur during or after hospitalization of the residents — in a manner that avoids creating a double-counting of resident deaths at hospitals in reported state COVID-19 death statistics.

» Enforce, without exception, New York state law requiring nursing homes to provide adequate care and treatment of nursing home residents during times of emergency.

» Require nursing homes to comply with labor practices that prevent nursing homes from pressuring employees to work while they have COVID-19 infection or symptoms, while ensuring nursing homes obtain and provide adequate staffing levels to care for residents' needs.

» Require direct care and supervision staffing levels that (1) are expressed in ratios of residents to Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants; (2) require calculation of sufficiency that includes adjustment based on average resident acuity; (3) are above the current level reflected at facilities with low CMS Staffing ratings; and, (4) are sufficient to care for the facility's residents' needs reflected in their care plans.

» Require additional and enforceable transparency in the operation of for-profit nursing homes, including financial transactions and financial relationships between nursing home operators and related parties, and relatives of all individual owners and officers of such entities with contractual or investor relationships with the nursing home. Through a variety of related party transactions and relationships, owners and investors of for-profit nursing homes can exert control over the facility's operations in a manner that extracts significant profit for them, while leaving the facility with insufficient staffing and resources to provide the care that residents deserve.

» Ensure that nursing homes invest sufficiently in effective training so staff can fully comply with infection control protocols. Hold operators accountable for failure to have clinically appropriate policies in place and to effectively train staff to comply with them.

» Support manufacturing of PPE to facilitate sufficient supply of PPE for purchase by nursing homes. Enforce requirements that nursing homes have sufficient inventory of PPE for all staff to be able to follow infection control protocols.

» Ensure that adequate COVID-19 testing is available to nursing home residents and employees and enforce requirements that nursing homes test residents and staff in accordance with DOH and the Centers for Disease Control and Prevention (CDC) evidence-based guidelines.

» Eliminate the recently enacted immunity provisions that can provide financial incentives to for-profit nursing home operators to put residents at risk of harm by refraining from investing public funds to obtain sufficient staffing to meet residents' care needs, to purchase sufficient PPE for staff, and to provide effective training to staff to comply with infection control protocols during pandemics and other public health emergencies.[5]

» Formally enact and continue to enforce regulatory requirements that nursing homes communicate with family members of residents promptly, but not later than within 24 hours of any confirmed or suspected COVID-19 infection and of any confirmed or suspected COVID-19 death.

» Increase staffing at DOH to ensure sufficient skilled resources for oversight, complaint assessment, surveys, inspections, and immediate responses to information requests from state agencies in support of health care and law enforcement efforts.

» Ensure that nursing homes engage in thoughtful planning regarding post-mortem care needs and implement and train staff on policies for dignified care of the remains of deceased residents.

» Urge families to consult the CMS Care Compare online database (medicare.gov/care-compare), ask questions of nursing homes relating to staffing, policies, procedures, and recent and current COVID-19 infections of staff and residents, and to obtain information relevant to their current or future long-term care decisions for their loved ones. Where possible, visit family member residents in person and through "window" visits and videocalls even if resident is unable to communicate, to provide emotional support and to enable observation of the resident's physical appearance and condition. Ensure family members know to report suspected neglect or abuse to DOH and OAG.

Timeline

On January 31, the Secretary of the U.S. Department of Health and Human Services (HHS) declared a public health emergency for the United States to aid the nation's health care community in responding to COVID-19. The emergency declaration gave state, tribal, and local health departments more flexibility to request that HHS authorize them to temporarily reassign personnel to respond to COVID-19.[6] While everyone is at risk of getting COVID-19, older adults and people of any age who have serious underlying medical conditions are at higher risk for more severe illness. In early February, DOH issued specific correspondence to health care facilities in New York directing them to plan for COVID-19. In early March, travel-related cases and community contact transmissions of COVID-19 were documented in New York. On March 7, Governor Andrew Cuomo declared a COVID-19 Disaster Emergency, declaring that a "disaster is impending in New York State, for which the affected local governments are unable to respond adequately."

New York took the brunt of the initial wave of COVID-19 infections from March through May, as reflected in the high number of COVID-19 infections and deaths. As reported in numerous sources, the New York City metropolitan area received the bulk of travelers from Europe prior to federal closure of international airports. From March through August 3, DOH reported a total of 6,423 resident deaths in nursing homes due to COVID-19, including 3,640 confirmed COVID-19 deaths and 2,783 presumed[7] COVID-19 deaths.[8] These reported deaths are based on data reported by New York's 619 nursing homes to DOH through its Health Emergency Response Data System (HERDS). As reported by *The New York Times*, there were 422,296 COVID-19 infections and 32,422 COVID-19 deaths in New York state as of August 4:[9]

Effect on Nursing Home Residents

A. Facility-Reported Deaths

In New York state, the first wave of the COVID-19 pandemic impacted many of the residents and staff of the 304 nursing homes located within the nine downstate counties in the New York City metropolitan area.[10] Within these counties, according to DOH, there were 2,567 confirmed COVID-19 resident deaths and 2,687 presumed COVID-19 resident deaths, for a total of 5,254 resident deaths in nursing homes from March through August 3. Of the total 6,423 reported resident deaths in nursing homes statewide as of August 3, 81 percent occurred in facilities in these nine downstate counties. (Through November 16, reports total 6,645 resident deaths due to COVID-19.)

Western, Northern, and Central New York also experienced COVID-19 infections in nursing homes during this time. According to DOH, from March through August 3, nursing homes upstate reported 1,169 resident deaths, including 1,073 confirmed COVID-19 deaths and 96 presumed COVID-19 deaths. The state's peak of nursing home resident COVID-19 reported deaths occurred on April 8.[11]

1. A Larger Number of Nursing Home Residents Died from COVID-19 Than Public DOH Data Reflected

Preliminary data analysis obtained from OAG inquiries to a portion of nursing homes during the pandemic suggests that many residents died from COVID-19 in hospitals after being transferred from their nursing homes.

OAG asked 62 nursing homes for information about on-site and in-hospital deaths from COVID-19 for the week of March 1 to the date of the facility's response, which varied from the week of April 12 to July 19. This sample of facilities – approximately 10 percent of the number of nursing homes in New York – was not randomly selected. OAG investigation teams requested data regarding resident deaths during the course of its preliminary investigations.[12]

Using the data from these 62 nursing homes, OAG compared: (1) in-facility deaths reported to OAG to in-facility deaths publicized by DOH, and (2) total deaths reported to OAG to total deaths publicized by DOH.[13]

The first comparison raised some questions, as shown on the chart below:

Deaths at Facilities – Comparison of Reports to OAG and DOH

Facility Deaths Reported to OAG	1,266
Facility Deaths Publicized by DOH	1,229
Difference	(37)
Over/Under Percentage	-3.01%

Although the calculated discrepancy of 3.01 percent may seem relatively low under the circumstances, closer analysis revealed that some facilities reported the location of the person at the time of death inconsistently. The discrepancies raise concerns because, when the data is removed for seven facilities that reported differing locations of death yet had a consistent total death count, the difference in reporting of deaths at the remaining 55 facilities jumps as publicized by DOH to **18.66 percent**. The DOH reporting system explicitly requires facilities to correct inaccurate reporting. Either such correction was not made by a number of facilities, or data were not reflected in DOH's published data for other reasons.

Total Deaths Reported to OAG (incl. residents sent to hospitals) vs. Publicized by DOH

Facility Deaths Reported to OAG	1,914
Total Deaths Publicized by DOH	1,229
Difference	(685)
Over/Under Percentage	-55.74%

The examples below illustrate that discrepancies remain even when the data reported to OAG is compared to data published by DOH as of later time periods through August 3:

» A facility reported 11 confirmed COVID-19 deaths at the facility, one suspected COVID-19 death at the facility, and four hospital deaths to DOH as of May 2020, and reported the same data to OAG. However, DOH published only one confirmed COVID-19 death at the facility until July 31, when its publication reflected eleven confirmed in-facility deaths -- a discrepancy of five deaths from what was reported to DOH by the facility. [14]

» A facility reported one confirmed and six presumed COVID-19 deaths at the facility as of August 3 to DOH. However, the facility reported to OAG a total of 31 COVID-19 suspected deaths at the facility as of April 18 – a discrepancy of 25 deaths.

» A facility reported five confirmed and six presumed COVID-19 deaths at the facility as of August 3 to DOH. However, the facility reported to OAG a total of 27 COVID-19 deaths at the facility and 13 hospital deaths – a discrepancy of 29 deaths.

Applying the data that these 62 nursing homes reported to OAG, which includes resident deaths occurring in the facility and in the hospital after transfer, shows a significantly higher number of resident COVID-19 deaths can be identified than is reflected in the deaths publicized by DOH.

OAG is investigating those circumstances where the discrepancies cannot reasonably be accounted for by error or the difference in the question posed.

In conclusion, this preliminary data for the 62 facilities and time periods noted above suggests that COVID-19 resident deaths associated with nursing homes in New York state appear to be undercounted by DOH by approximately 50 percent. [15]

2. High Numbers of Deaths at Nursing Homes During the Pandemic Exceeded Morgue Capacity and High Volumes of Deaths Citywide Exceeded Capacity of County Medical Examiners and Funeral Homes

OAG preliminary investigations indicate that in April, six New York City nursing homes experienced resident death numbers that exceeded the facilities' onsite morgue capacity. In each of those instances, the facility appropriately contacted funeral homes or the medical examiner's office. However, the high numbers of COVID-19 deaths across New York City had filled the capacity of local medical examiners and funeral homes. As a result, there were times when several days passed before remains could be transported out of the facilities.[16] Media reports in New York City during the peak of the first wave of the pandemic contained allegations that bodies of deceased residents were "piling up"[17] [18] inside a number of nursing homes. OAG investigated these allegations.

OAG determined that the allegations were unfounded with respect to two of the six nursing homes. In three for-profit facilities, OAG determined that the remains awaiting transfer were stored in accordance with accepted industry practice, which is to place the bodies in unoccupied patient rooms with the air conditioning on full power and with doors sealed. In an investigation of one not-for-profit facility, OAG determined that deceased residents' bodies awaiting transfer were appropriately stored in rented refrigerated trucks in the parking lot of the facility.

Under the circumstances, the preliminary investigations indicate no violation of law or industry practice in the storage of the remains of deceased residents. These incidents raise the question of whether the facilities engaged in enough planning. Relatedly, some staff conveyed surprise and shock at the discovery of onsite storage of remains other than in the morgue, indicating internal communication and training lapses.

Guidance Issued by Federal and State Governments

Federal and state agencies issued and updated guidance from January to May as evidence and knowledge about COVID-19 developed. During the pandemic, Governor Cuomo issued many executive orders in an effort to flatten the rising curves of COVID-19 infection and death rates, including directing New York to be "On Pause," and requiring the public to wear masks and practice social distancing. In addition, CDC, CMS, and DOH issued guidance relative to COVID-19. As the virus spread through New York and other states and countries, more information was promulgated about COVID-19 infection, illness, and treatment, prompting federal and state health agencies to issue updated guidance. Much of this information contained reminders and updates about best practices for containment and control of respiratory viruses – a disease vector well understood in health care facilities. This guidance also reflected updates on evolving medical knowledge about COVID-19.

A chronology of key guidance and directives issued by CDC, CMS, DOH, and Governor Cuomo that relates to nursing homes appears in the table in Appendix A.

* * *

With these health care directives as background, OAG conducted the investigations described in the following sections.

Methodology: Phase One Investigations, Hotline Reports, and Data Analysis

OAG used three investigative approaches for this report. First, OAG opened a hotline to receive reports of violations of executive orders concerning communications with families, which expanded to receive reports of abuse and neglect. Second, OAG analyzed data from CMS and DOH for correlations between COVID-19 outcomes and CMS facility ratings. Third, OAG followed up on direct or media reports of potential abuse or neglect due to COVID-19. OAG conducted preliminary, or phase one, investigations of many nursing homes, and has continued and expanded investigations with respect to a number of them.

Except where noted, this preliminary report excludes information from enforcement investigations, and, where such information is set out, portions were redacted or paraphrased to protect the investigation or privacy of individuals not accused of wrongdoing. Names of individuals or business entities have been redacted, unless the person was convicted of criminal conduct or named in public filings such as settlement agreements or Assurances of Discontinuance under Executive Law § 63(12).

A. Phase One Investigations of Nursing Homes Conducted by OAG During the First Wave of the Pandemic

Based on allegations of COVID-19 related neglect received as of August 9, OAG conducted phase one investigations into 174 nursing homes statewide. Preliminary findings in this report are based on information obtained in the investigations, and the other data referenced herein. The data obtained during these investigations includes interviews conducted by telephone, documents obtained from nursing homes and third parties, and surveillance conducted. These complaints and investigations included facilities everywhere in the state. Based on the preliminary investigations, OAG is continuing investigations of over 20 facilities in greater depth.

Upon receipt of these allegations, OAG investigative teams followed up with complainants and promptly contacted the nursing home in question to determine whether substandard infection prevention and control practices existed at the reported home that could endanger residents, or if critically low staffing existed to the same effect. In the vast majority of these instances, the subject nursing homes cooperated fully. The primary goal of the initial inquiries was to determine whether, among other things, each facility reported having PPE and proper infection control protocols in place, and whether, based on the staffing and other conditions reported, the residents appeared to be in danger. If OAG concluded that alleged circumstances at a facility presented likely and significant risks of harm to the residents, OAG referred those facilities to DOH for immediate action. DOH responded to such facilities, including with onsite teams. A DOH referral does not mean that OAG closed its own investigation.

B. Attorney General James' COVID-19 Hotline

OAG opened a dedicated internet and telephone hotline on April 23, to address public and inter-agency concerns about a lack of prompt and effective compliance with Executive Orders 202.18 (April 16) and 202.19 (April 17) concerning communications with family members. The executive orders require nursing homes and assisted living facilities to notify "family members or next of kin of residents" within 24 hours when a resident of the facility either tests positive for COVID-19 or suffers a COVID-19-related death.

Earlier DOH guidance that was issued on April 4 similarly encourages a broader range of communication with families, including notifying families of all residents when anyone who has been in the facility has actual or suspected COVID-19, and encouraging frequent communication through direct and internet means on the status of prevention efforts in the facility. The guidance applies to all facilities and provides communications best practices for facilities with and without COVID-19 cases. CDC issued similar guidance on March 13.

Immediately before opening the hotline, OAG received numerous reports that nursing homes across New York were doing a poor job of such communication. The most concerning reports indicated some families were not even informed that their family member was ill prior to hearing of their death. The reports also suggested that some facilities were extremely insensitive in their communications.[19]

As only a violation of the executive orders were immediately sanctionable, which could not be accomplished in the short-run, OAG's main goals were to:

» Identify facilities doing a poor job of compliance with, or violating, the executive orders;

» Communicate with facilities and require them to change practices immediately; and,

» Communicate with DOH, if necessary, to solve these and other problems.

OAG employees responded to each caller, and, with the information from such discussions, often made further contact directly with facility administration. From April 23 through November 16, the hotline received 953 contacts, the vast majority of which were received through August 3 (774 complaints). Of the complaints received through August 3, 653 related to identifiable facilities in the state. In those communications, 276 different facilities were named. Notably, these facilities were located throughout the state and were not over-represented in the areas initially hardest hit by COVID-19 deaths. This wide geographic distribution strongly indicates that even though some of the facilities were not immediately challenged by extremely ill residents, they were nonetheless unprepared to handle relatively basic communication issues. (While a few calls also named hospitals or assisted living facilities, they do not significantly alter the numbers or distribution.)

MFCU Nursing Home COVID-19 Hotline Intake by Region 4/23/2020 – 8/3/2020 [20]

New York Region (with Counties of Facilities Subject of Intakes)	Number of Intakes
Capital Region *Albany, Columbia, Greene, Rensselaer, Schenectady, Warren, and Washington*	68
Central New York *Cayuga, Madison, and Onondaga*	24
Finger Lakes *Livingston, Monroe, Orleans, and Wayne*	35
Long Island *Nassau and Suffolk*	130
Mid-Hudson *Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester*	104
Mohawk Valley *Fulton, Herkimer, Montgomery, Oneida, and Otsego*	16
New York City *Bronx, Kings, New York, Queens, and Richmond*	196
Southern Tier *Broome, Chemung, and Steuben*	24
Western New York *Erie and Niagara*	56
Total	653

OAG staff were able to address the bulk of these hotline contacts through a variety of interventions, including:

» Direct communication to facilities, with verbal or written warnings in some instances;

» Direct communication to facilities, identifying weaknesses and connecting people;

» Referrals to OAG investigation teams for longer-term follow-up;

» Comfort and clarity to family members who were not well informed of their options and avenues for communications.

While the executive orders and DOH guidance used the non-specific term "family," most facilities keep contact information and privacy authorizations for "designated representatives" or "next of kin." Given the wide variety of human relationships, the phrases can indicate different individuals within a given family or other individuals acting pursuant to a resident's designation. Greater precision as to such legal terms in future guidance would help clarify expectations of family members in their communications with facilities.

Preliminary Findings from OAG Investigation and Data Analysis

OAG's investigations conducted during and in the aftermath of the first wave of the pandemic reflect preliminary findings as to factors that increased risks of COVID-19 transmission to nursing home residents.

A. Lack of Compliance with Infection Control Protocols Put Residents at Increased Risk of Harm During the COVID-19 Pandemic in Some Facilities

During phase one investigations, OAG received multiple reports through the COVID-19 hotline and direct communications to OAG that several nursing homes failed to implement proper infection controls to prevent or mitigate the transmission of COVID-19 to vulnerable residents. Among those reports were allegations that, despite medical best practices, existing regulations, and specific COVID-19 guidance from CDC, CMS, and DOH, several nursing homes in all regions of the state failed to plan and take proper infection control measures, including:

» Failing to properly isolate residents who tested positive for COVID-19;

» Failing to adequately screen or test employees for COVID-19;

» Demanding that sick employees continue to work and care for residents or face retaliation or termination;

» Failing to train employees in infection control protocols; and,

» Failing to obtain, fit, and train caregivers with PPE.

1. Pre-Existing Infection Control Requirements for Nursing Homes

Infection prevention and control has long been a fundamental aspect of basic nursing home care. Nursing homes are expected to take all reasonable steps to avoid the transmission of disease. Never was this obligation more important than during the early stages of COVID-19, nor will it be less important as we continue to navigate through this global pandemic. Nursing home infection control regulations, which have been in effect for years, require every nursing home to maintain an infection control program with policies designed to provide a safe, sanitary, and comfortable environment in which residents vulnerable to infection reside (and where their health care providers work).[21] A facility is required to have an infection control program in which the facility: (1) investigates, controls, and takes action to prevent infections in the facility; (2) determines what procedures, such as isolation, should be utilized for an individual resident to prevent continued transmission of a disease; and, (3) maintains a record of incidence and corrective actions related to infections. Nursing homes are required to isolate residents and properly sterilize and store all equipment to prevent the spread of infection. Facilities are required to mandate basic infection control practices including ensuring staff wash their hands after each direct resident contact and properly handle and store linens.[22]

2. Health Oversight Agencies Directed Nursing Homes to Strengthen Pre-Existing Infection Control Policies at the Onset of the COVID-19 Pandemic

On March 11, DOH issued COVID-19 guidance to nursing homes setting forth the facts of the virus as known at the time, DOH's expectations of nursing homes during the pandemic, and applicable infection control procedures that each facility was required to follow to ensure the safety of residents and staff during the COVID-19 outbreak. Citing the nationally reported COVID-19 outbreak at the Life Care Center nursing home in the state of Washington in late February, DOH warned New York nursing homes that the "potential for more serious illness among older adults, coupled with the more closed, communal nature of the nursing home environment, represents a risk of outbreak and a substantial challenge for nursing homes." DOH noted that it was "essential" that all nursing homes "maintain situational awareness about the disease, its signs and symptoms, where cases and outbreaks are occurring, and necessary infection prevention and control procedures by regularly visiting" CDC and DOH websites to review the most up-to-date information. DOH advised nursing homes that they "must review and reinforce their policies and procedures with all staff, residents, and visitors regarding infection prevention and control."[23]

In addition to DOH's continuing COVID-19 guidance and pre-existing New York nursing home regulations mandating strict infection controls, federal health oversight agencies also issued guidance and directives to the nursing home sector to tighten infection control measures to protect nursing home populations. As early as February 6, CMS issued guidance noting that "[b]ecause coronavirus infections can rapidly appear and spread, facilities must take steps to prepare, including reviewing their infection control policies and practices to prevent the spread of infection."[24] On March 13, CMS issued directives to nursing homes nationally to prevent the further spread and transmission of the virus to "America's seniors, who are at highest risk for complications from COVID-19," including:

» Restricting all visitors except for compassionate care, such as end-of-life situations;

» Restricting all volunteers and nonessential personnel;

» Canceling all group activities and communal dining; and,

» Screening residents and personnel for fever and respiratory symptoms.

In conjunction with CMS's directives, CDC issued several notices including a coronavirus "Preparedness Checklist for Nursing Homes and other Long-Term Care Settings," as "one tool in developing a comprehensive COVID-19 response plan."[25] The checklist identified key areas that long-term care facilities should consider in their COVID-19 planning. It also included several key planning recommendations, such as incorporating COVID-19 into written emergency plans[26] and instructions on infection control policies.

3. Examples of Preliminary Findings Regarding Infection Control Practices

Below is a representative factual summary of some of the allegations received by OAG from March 11 to June 30 regarding infection control. Given that this is a preliminary report, the sources of the information and the subject nursing homes will remain confidential to protect the identity of witnesses and the integrity of ongoing investigations.

These factual summaries are not meant to convey legal conclusions. The examples laid out represent facilities that are under investigation that could result in legal action, facilities that are no longer under investigation due to lack of evidence or confirmed wrongdoing, and facilities that OAG is continuing to closely monitor.

Starting in March, OAG received several reports from concerned staff and family members that nursing homes failed to ensure proper infection prevention and control practices. In OAG's COVID-19 rapid-response model, investigative teams followed up on these reports, interviewed key staff at the subject nursing homes, and, if necessary, reviewed records produced by the facilities either voluntarily, pursuant to OAG's authority to demand the production of records under 18 NYCRR § 504.3 or by subpoena pursuant to New York Executive Law § 63(12). OAG determined that several of these reports required additional investigation or referral to DOH.

CMS Star Ratings – Staffing versus Overall

The CMS Staffing rating is a separately published rating for each facility. It is also a component of the rating published as the Overall rating of a facility, along with two other separate ratings. The Staffing rating specifically reflects the number of staffing hours in the nursing department of a facility relative to the number of residents. This ratio is expressed as a star rating, with the lowest rating of 1-Star signifying the lowest number of staff per resident, and the highest rating of 5-Star signifying the highest number of staff per resident.

On March 1, 21 percent of New York's 619 nursing homes had very low Staffing and/or Overall ratings, as shown in this chart:

Category	Number of New York State Nursing Homes
CMS 1-Star Staffing rating *(22 of which has 1-Star Overall ratings)*	75
CMS 2-Star Staffing rating and 1-Star Overall rating	58

a. Failure to Isolate COVID-19 Residents Put Residents and Staff at Increased Risk of Harm

OAG received several credible reports from concerned staff and family members that nursing homes failed to promptly isolate residents who they knew or presumed to have had COVID-19. For example, in early April, a Certified Nursing Assistant (CNA) from a for-profit nursing home in New York City with CMS 2-Star Staffing and 4-Star Overall ratings reported that residents who tested both positive and negative for COVID-19 were simply treated with Tylenol, without isolation, or any other specific respiratory care. A few days later, OAG received a report from a member of the family council of the same nursing home alleging several concerns about how the facility responded to the COVID-19 pandemic. Among the complaints was that the facility was not properly sanitizing rooms of residents after they were transferred from the rooms.

Early in the COVID-19 pandemic, OAG began a preliminary investigation into a for-profit nursing home in New York City due to indications of neglect, including: a high number of resident deaths, poor performance during past DOH inspections, and the lowest possible CMS ratings (1-Star Staffing and 1-Star Overall). OAG received reports of multiple problems at the facility, including failure to isolate residents who tested positive for COVID-19. CDC and DOH conducted an infection control survey and found that the facility, while in need of policy changes, was in compliance with New York and federal infection control guidelines.

In mid-May, OAG received an anonymous call to the hotline in which the caller indicated that COVID-19 positive residents at a for-profit nursing home north of New York City with CMS 3-Star Staffing and 3-Star Overall ratings were intermingled with the general population for a period of time that allegedly ended in mid-May, when the facility started using its first floor as the designated COVID-19 floor. During an interview conducted by OAG investigators shortly thereafter, the administrator stated that the facility had not yet created a "COVID-19 only" unit but that it had placed COVID-19 positive residents in private rooms. He indicated at that time that the facility was planning on using one floor or part of a floor just for those residents.

b. Continued Communal Activities, Including Communal Dining, Put Residents and Staff at Increased Risk of Harm

In late April, weeks after communal activities, including communal dining, were restricted by CMS and DOH, OAG received an allegation from a family member of a resident that a for-profit Long Island nursing home with CMS 2-Star Staffing and 3-Star Overall ratings was still operating communal dining. OAG investigators promptly contacted the facility staff who admitted to OAG investigators that "aspiration precaution"[27] dementia residents were still being brought into the dining room for meals irrespective of COVID-19 status. They stressed that social distancing was observed and that only one resident would be allowed to sit at a table that typically would accommodate six residents. They explained that the decision to continue communal dining was made given the elevated levels of supervision required for residents at risk of aspirating. This purported safety concern directly implicates staffing. Aspiration precautions requires fewer staff if done in a group setting. After the OAG interview, the facility reportedly changed its policy and ensured that all residents would take meals in the rooms under appropriate supervision depending on each resident's care plan.

c. Lax Employee Screening Put All Residents and Staff at Increased Risk of Harm

OAG received reports that nursing homes did not properly screen staff members before allowing them to enter the facility to work with residents. Among those reports, OAG received an allegation that a for-profit nursing home north of New York City with CMS 2-Star Staffing and 4-Star Overall ratings failed to consistently conduct COVID-19 employee screening. It was reported that some staff avoided having their temperatures taken and answering a COVID-19 questionnaire at times when the facility's front entrance screening station had no employee present to conduct the screening, and when staff entered through a back entrance to the facility.

d. DOH Inspections Increased Facility Compliance with Infection Control Protocols

During an inquiry at a for-profit Western New York facility with CMS 1-Star Staffing and 1-Star Overall ratings, a Registered Nurse (RN) reported to OAG that immediately prior to the facility's first DOH inspection in late April, a nurse supervisor had set up bins in front of the units with gowns and N95 masks to make it appear that the facility had an adequate supply of appropriate PPE for staff. The RN alleged that the nurse supervisor came in to work unusually early at 5:30 AM the day of the first inspection and brought out all new PPE and collected all of the used gowns. Although the initial DOH survey conducted that day did not result in negative findings, DOH returned to the facility for follow-up inspections, issued the facility several citations, and ultimately placed the facility in "Immediate Jeopardy." "Immediate Jeopardy" means a deficiency has resulted in the provider's noncompliance, "has caused or is likely to cause serious injury, harm, impairment or death to the residents" and immediate action is necessary to address it.[28]

It was also reported to OAG that at a for-profit nursing home on Long Island with CMS 2-Star Staffing and 5-Star Overall ratings, COVID-19 patients who were transferred to the facility after a hospital stay and were supposed to be placed in a separate COVID-19 unit in the nursing home were, in fact, scattered throughout the facility despite available beds in the COVID-19 unit. According to the report, this situation was resolved only after someone at the facility learned of an impending DOH infection control survey scheduled for the next day, before which those residents were hurriedly transferred to the appropriate designated unit.

CMS and DOH conducted onsite infection control surveys at nursing homes statewide, which helped decrease risks to residents.[29] DOH provided infection control support in an effort to enforce compliance with regulations and guidance designed to protect residents. While these efforts helped, OAG's preliminary investigations indicate that nursing homes' lack of compliance with infection control protocols resulted in increased risks to residents at a number of facilities.

B. Nursing Homes with Low CMS Staffing Ratings Had Higher COVID-19 Fatality Rates

Most of the state's nursing homes are for-profit, privately owned and operated entities. There were 401 for-profit facilities, 189 not-for-profit facilities, and 29 government facilities statewide as of June 1. Not-for-profit facilities operate for the charitable purpose set forth in their charters. Government facilities have a public service mission. For-profit facilities are, by definition, operated with a goal of earning profit. 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.

While New York has minimal staffing level requirements for nursing homes, nursing homes require sufficient staffing levels on a daily basis and over the long haul in order to be able to provide the care required by New York law, including by individualized resident care plans. The main direct caregivers in a nursing home are, in order of training, CNAs, Licensed Practical Nurses (LPN), and RNs. These staffers are the bulk of the caregivers in a facility and have primary, daily contact with residents. 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. LPNs primarily focus on medication administration, monitoring vital signs, and providing certain treatments. RNs primarily focus on acute care needs, complex treatments, compliance with medical orders, communication with physicians and specialists, record-keeping, and complex health assessments.

Data presented in Appendix B hereto reflects that financial incentives within the current system result in a business model in too many for-profit nursing homes that: (1) seeks admission of increased numbers of residents to reach census goals; (2) assigns low numbers of staff to cover the care needs of as many residents as feasible; and, (3) transfers facility funds to related parties and investors that the home could otherwise invest in staffing to care for residents – essentially taking profit prior to ensuring care. In this model, hiring additional staff above the numbers set in low staffing models, and/or offering a higher wage in order to obtain more employees in the current labor market, are viewed as optional and unnecessary expenses. OAG's past cases and ongoing investigations reflect that this business model too often also includes extracting and transferring revenue received by for-profit nursing homes to related parties in a manner that enriches entities and individuals who have control over the nursing home, as well as their family members and business associates, at the expense of resident care and safety. These transfers of funds from such for-profit nursing homes occur through a variety of complex contractual relationships and transactions between private parties in order to enhance profit for owners, investors, landlords, and other private parties with relationships to the nursing home owners and operators, even though New York regulations prohibit directly extracting capital from a facility unless certain criteria are met. Notably, almost all revenue for nursing homes is from public funds — Medicare, Medicaid, and other state and federal programs — as well as funds such as retirement-benefit health insurance. Before the pandemic, OAG investigations, prosecutions, and civil actions reflected that this low staffing business model had created conditions of systemic causes of resident neglect and abuse at a number of facilities. *See, e.g.,* Appendix B, B-1, and B-2 below, for an illustration of this business model.

Given the complaints of neglect received during the COVID-19 pandemic[30] and the OAG investigation findings to date, the pandemic has laid bare the risks to vulnerable nursing home residents that are inherent in a low staffing business model.

Pre-existing insufficient staffing levels in many nursing homes put residents at increased risk of harm during the COVID-19 pandemic. As nursing home resident and staff COVID-19 infections rose during the initial wave of the pandemic, staffing absences increased at many nursing homes. As a result, pre-existing low staffing levels decreased further to especially dangerous levels in some homes, even as the need for care increased due to the need to comply with COVID-19 infection control protocols and the loss of assistance from family visitors.

1. Preliminary Investigative Findings Regarding Low Staffing Levels

COVID-19 and Staffing Shortages: OAG's preliminary investigations reflect many examples where for-profit nursing homes' pre-pandemic low staffing model simply snapped under the stress of the pandemic:

» OAG received a complaint from a resident's son about a for-profit nursing home in New York City with CMS 2-Star Staffing and 5-Star Overall ratings. The complaint alleged critically low staffing levels at the facility and the resident's son voiced concern about the care his mother was receiving. His mother was never tested for COVID-19, but later died while exhibiting COVID-19 symptoms. For several weeks, the facility was short of caregivers due to COVID-19 illness and quarantine, and most of its management was either out ill or working remotely. During one period of time between late March and early April, the director of nursing, the assistant director of nursing, and the medical director were all out ill and the administrator was working from home, leaving onsite management of the entire facility in the hands of just two nurse supervisors. Two to three weeks later, residents started dying from COVID-19. During the week of April 5, 33 residents died – 15 percent of all the patients in the facility. In mid-April, the administrator was overwhelmed and stated that the facility's greatest need was staffing.

» A for-profit facility in Western New York with CMS 1-Star Staffing and 1-Star Overall ratings was named in multiple reports from employees for having insufficient staffing, especially on the weekends. One CNA reported that on a day in late March, for at least a few hours, there was only one CNA in the entire building of approximately 120 residents. She also reported that on a day in mid-April, there was one CNA on each hall, one RN to cover the Rehabilitation and Dementia units, and one supervisor performing double duty by dispensing medication from two medicine carts. An RN stated that during a weekend late in May, during the day shift, one nurse called out and another nurse was a "no call no show," leaving one nurse for the entire building. The same RN stated that on a later day in May, she worked an overnight shift for which she was the only nurse for three units. Facility records indicate that only one nurse was on duty during the day shift the following day. Another employee alleged that the staffing levels at the facility were so low that CNAs, rather than nurses licensed to do so, were dispensing medications to residents. According to various staff members, the facility required staff who were not licensed clinicians to take an eight-hour temporary CNA course and to cover shifts working as CNAs.[31]

» A for-profit nursing home in New York City with CMS 2-Star Staffing and 5-Star Overall ratings indicated that in late March and early April, the facility's low staffing levels were decreased further due to staff illness and quarantine from COVID-19. A nursing supervisor alleged in mid-April that she had been working for 21 days straight, 14 hours per day, and described a facility stretched to the absolute limit to care for its residents. The following week, the nurse and the administrator conveyed that staffing levels had improved and that staff who had been out sick and quarantined were returning to work, staff were working extra shifts, and the facility used agency staffing of direct caregivers to supplement care provided by facility employees. The facility reported to OAG that it had 32 COVID-19 deaths during the three-week period with decreased staffing.

Preliminary investigations also indicate that residents at a number of facilities with pre-existing low CMS Staffing ratings faced other, predictable, increased risks. As nursing home resident and staff COVID-19 infections rose during the first wave of the pandemic, staffing absences increased at many nursing homes. Often, as health care workers became infected with COVID-19, they were either asymptomatic and continued working, or became ill and/or were required to self-quarantine under CDC and DOH guidance. When low staffing levels dropped further due to staff COVID-19 illness or quarantine, there were even fewer staff available to care for residents' needs at these facilities. At the same time, when residents had COVID-19, their individual and collective care needs increased due to the need to comply with COVID-19 infection control protocols. This need increased the workload for the remaining staff providing direct care in several respects, even as low staffing numbers dropped further. These decreases in staffing levels occurred at the same time that necessary visitation restrictions removed the supplemental caregiving provided pre-pandemic by many family visitors at low staff facilities.

In addition, preliminary investigations indicate that when there were insufficient staff to care for residents, some nursing homes pressured, knowingly permitted, or incentivized existing employees who were ill or met quarantine criteria to report to work and even work multiple consecutive shifts, in violation of infection control protocols. Thus, poor initial staffing before the pandemic meant even less care for residents during the pandemic: subtraction of any caregivers from an already under-staffed facility results in increased interaction among possibly infectious staff and residents, with less time for the staff to adhere to proper infection control precautions.

In addition to the examples discussed below, during an investigation of an upstate for-profit facility with CMS 2-Star Staffing and 2-Star Overall ratings, a manager said the facility had 14 known staff members who tested positive for COVID-19 and was following all CDC guidelines before allowing COVID-19 positive staff members to return to work, which had made staffing an issue. A CNA alleged that it was common to have only one or two CNAs per unit since the COVID-19 pandemic started. The CNA added that prior to this, there were "some" staffing issues but it "was not this bad." The CNA alleged residents are "lucky" to "get toileted and cleaned up once a shift…there is not enough time in the day to do it more than that." According to a nurse manager, the facility used DOH's database to hire more CNAs, which led to an improvement in staffing.

DOH Staffing Portal Helped: As reflected in the example above, during the COVID-19 pandemic, DOH referred facilities to an online staffing portal to help provide temporary assistance when they were experiencing staffing shortages due to staff illness and quarantine. This resource helped several nursing homes address staffing problems.

Multiple Complaints of Insufficient Staffing: OAG received several other complaints and allegations of insufficient staffing due to COVID-19 in facilities that had pre-pandemic low CMS Staffing ratings:

» The daughter of a resident at a for-profit facility north of New York City with CMS 2-Star Staffing and 5-Star Overall ratings reported that the facility experienced even lower staffing in May. The daughter said that the facility was short-staffed and that employees said the facility "forgot" to call her for about a week to inform her that her father tested positive for COVID-19.

» Complaints regarding a for-profit nursing home in New York City with CMS 1-Star Staffing and 1-Star Overall ratings claimed the facility experienced staffing absences early in the pandemic, but reportedly addressed these shortages by contracting or hiring additional staff.

» An employee complained that a for-profit nursing home on Long Island with CMS 2-Star Staffing and 5-Star Overall ratings had an insufficient number of staff due to staff being out sick. The facility reportedly tried to fill vacant positions by using staffing agencies but said there was a limited pool of personnel from which it could hire. It later reportedly supplemented staffing with agency staffing.

» A staff member at a for-profit nursing home on Long Island with CMS 2-Star Staffing and 3-Star Overall ratings alleged low staffing levels. Facility management acknowledged that low staffing levels had decreased from the pre-pandemic level to an insufficient level due to staff being out sick or being unable to work due to the need to care for the staff's family members. The facility sought to address the vacancies by incentivizing staff to work additional shifts, specifically by paying bonuses and by paying "hazard pay," which is additional pay above the employee's salary to compensate for working in an environment where COVID-19 infection exists and therefore presents increased health risks to the employee.

» A staff member at a for-profit nursing home on Long Island with CMS 4-Star Staffing and 4-Star Overall ratings alleged, and the facility acknowledged, that low staffing levels had decreased from the pre-pandemic level to an insufficient level, due to staff being out sick or being unable to work due to the need to care for the staff's family members. The facility sought to address the vacancies by paying $2 per hour more in hazard pay to incentivize staff to work additional shifts and by utilizing staffing agencies to provide per diem staff.

» Management at a for-profit nursing home in New York City with CMS 1-Star Staffing and 3-Star Overall ratings admitted that the facility experienced a shortage of staff below pre-pandemic levels from the end of March to the beginning of April. At the time of the preliminary investigation, the facility stated that its employees were stepping up and working double and triple shifts, with managers helping as well by distributing medications and filling in to help with some of the tasks that needed to be done to care for the residents.

OAG's phase one investigations also found that under conditions of pre-existing low staffing levels that were exacerbated by COVID-19, many nursing homes placed frontline health care workers under incredibly challenging and exhausting circumstances for extended periods of time, where they pushed themselves to the brink physically and emotionally. While working in an environment in which they knew COVID-19 was present and posed health risks to themselves and their families, many direct care staff worked multiple double shifts, repeatedly and over extended periods of time, doing incredible and compassionate work in attempt to care for the needs of many isolated, vulnerable, and ill residents. OAG heard many reports of direct care workers pushing themselves under extremely challenging circumstances of insufficient staffing — to the point of exhaustion, serious illness, and in some cases, the ultimate sacrifice of their own lives.

Many nursing homes mandated or encouraged health care workers to work multiple double shifts, repeatedly and over extended periods of time, because their pre-pandemic low staffing levels decreased further during the pandemic. Preliminary investigations illustrate that a number of health care workers believed that unless they worked under these strenuous conditions to provide necessary care to the residents, their needs would otherwise have gone unmet, in light of the nursing home's decisions on staffing levels.

When staffing levels decreased in low staffed facilities, the workload of RNs, LPNs, and CNAs increased in volume in four ways: (1) workers had to perform extra steps in caring for residents that were required to comply with COVID-19 infection control protocols; (2) workers' duties to provide more care to residents also increased as residents became ill with COVID-19; (3) workers' assignments also changed as staffing levels dropped and they were required to provide care to an increased number of residents in a single shift; and, (4) workers also often had to work a higher total number of hours per day or week when they were mandated or volunteered to work multiple shifts to cover for call-outs or other staff absences. The stress on direct care providers working under these circumstances for a prolonged period of time predictably took a heavy toll on their health and well-being. It also imposed a practical limit on the number of hours of caregiving these individuals could work over a sustained period of time. While the owners of for-profit nursing homes that operate in a low staffing business model have the power to change this dynamic, OAG's investigations reflect that they lack the motivation to do so. The results are tragic and, at this point, predictable, even as the second wave of COVID-19 continues.

Staffing Shortages Impacted Infection Control Compliance: As previously discussed, preliminary investigations indicate that infection control within nursing homes was a significant problem during the pandemic. At the same time that nursing homes with pre-pandemic low staffing levels were experiencing decreased staffing due to COVID-19, the staff's capacity to provide care to residents decreased because complying with infection control protocols required investing additional time in their duties. Reports also reflect instances where low staffing levels resulted in staff perceptions that the facility pressured them to work in violation of infection control protocols and other guidance that was designed to protect residents.

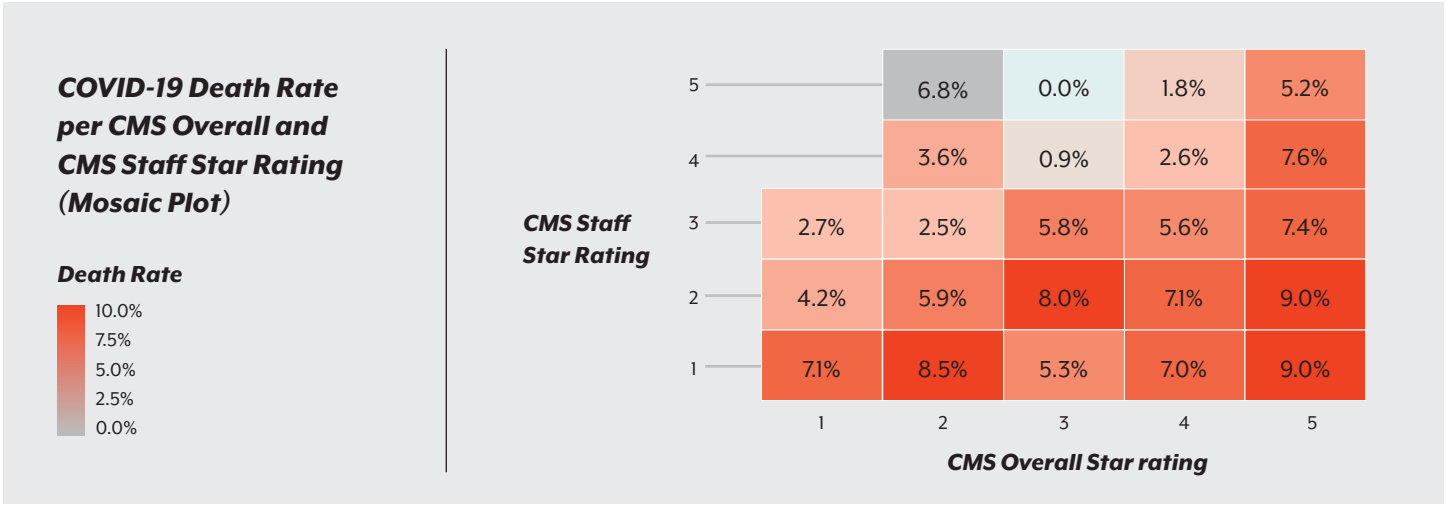
2. CMS Staffing Ratings Correlate More Strongly with COVID-19 Death Rates than CMS Overall Ratings

OAG's preliminary analysis, based on DOH's published[32] statistics of deaths in nursing homes from confirmed COVID-19 cases and presumed COVID-19 cases, shows a strong correlation to the CMS Staffing rating.[33] Nursing home residents died at a higher rate – deaths per average population of residents — in facilities that entered the COVID-19 pandemic with low CMS Staffing ratings. This data reflects that facilities with the highest CMS Staffing ratings had much lower death rates.

OAG's data analysis set forth in this preliminary report relies primarily on two data sources: the data made available through the "CMS Care Compare" website and DOH's daily reports of nursing home COVID-19 deaths. The New York state data, "Nursing Home and ACF COVID Related Deaths Statewide", are a publication by DOH of statistics self-reported by nursing homes and adult care facilities to DOH during the COVID-19 pandemic. As previously noted, OAG found discrepancies between COVID-19-related death data publicized by DOH and information reported to OAG during investigations. For the death data analysis below, OAG used the DOH-published figures, except where noted. The analysis revealed that most nursing home residents live in a CMS 1-Star or 2-Star Staffing rated facility. To avoid skewing the rate of COVID-19 deaths, OAG divided the total COVID-19 death count in each facility by the total resident count in each facility. This calculation results in a direct comparison across all facilities, which produces a COVID-19 death rate uninfluenced by the census of CMS 1-Star and 2-Star Staffing rated facilities.

With the exception of certain combinations of data points, the death rate increases as the CMS Staffing rating decreases, regardless of the CMS Overall rating. Thus, nursing home facilities with CMS 5-Star Overall ratings still saw the highest death rates if they had CMS 1-Star or 2-Star Staffing ratings. Indeed, facilities with 3-Star Overall ratings evinced lower death rates if their base staffing levels were high.

In the chart below, facilities with CMS 5-Star Overall ratings had an observed death rate of nine residents out of every 100 when their CMS Staffing rating was 1-Star or 2-Star. That rate dropped nearly by half, to five out of 100, if the facility had a CMS 5-Star Staffing rating.[34] Relatedly, facilities with low CMS Staffing ratings had higher death rates than similar CMS Overall rated facilities.[35] The chart includes all deaths from March 1 to November 16.



a. The Majority of the COVID-19 Reported Nursing Home Deaths Occurred in CMS 1-Star and 2-Star Staffing Rated Homes

As of November 16, DOH reported 6,645 nursing home COVID-19 resident deaths (confirmed and presumed). Nursing homes with CMS 1-Star or 2-Star Staffing ratings represented an outsized number of deaths, as compared to nursing homes with higher CMS Staffing ratings.

Table A — Distribution of Nursing Home Deaths as of November 16 by CMS Staffing Rating

CMS Staffing Rating as of 6/1	Number of Facilities	Percentage of Total Facilities	Total COVID Deaths 11/16	Percentage of Total	Total Average Census 6/1	Death rate per Resident
1	77	12.44%	975	14.67%	13,671	7.13%
2	266	42.97%	3426	51.56%	49,542	6.92%
3	169	27.30%	1611	24.24%	28,975	5.56%
4	68	10.99%	478	7.19%	9,329	5.12%
5	31	5.01%	97	1.46%	1,965	4.94%
NO RATING	8	1.29%	58	0.87%	600	9.67%

Of the state's 401 for-profit facilities, over two-thirds – a total of 280 – entered the COVID-19 pandemic with CMS 1-Star or 2-Star Staffing ratings.[36] As of November 16, 3,487 COVID-19 resident deaths (over half of all deaths) occurred in these 280 facilities. Also concerning has been the recent trend observed by OAG of for-profit owners buying not-for-profit nursing homes in transactions that result in more for-profit facilities.[37]

b. Staffing Was More Determinative of Death Rates Than "COVID-19 Geography" During the Initial Wave of the Pandemic

As noted by DOH, the harshest impact of the first wave of COVID-19 was in New York City and neighboring counties, which reflect eight of the ten highest populated counties in the state. Those counties also host the greater number of CMS 5-Star Staffing rated facilities as well as the greatest number of CMS 5-Star Overall rated facilities. As DOH noted, even 5-Star Overall rated facilities in those counties had high death rates.[38]

However, OAG found that when controlling for geographic variance among nursing facilities, CMS 5-Star Staffing rated facilities nonetheless suffered a lower death rate compared to facilities with low CMS Staffing ratings.[39] Thus, a resident anywhere in New York was likely to face roughly half the risk of death from COVID-19 if cared for in a CMS 5-Star Staffing rated facility.

Weighted Death Rate Controlled for Geographic Variance, by CMS Staffing Stars

Star Rating	*Overall weighted death rate*	*Staffing weighted death rate*
1	5.56%	6.03%
2	5.59%	6.94%
3	6.89%	7.56%
4	5.83%	6.07%
5	6.60%	2.97%

C. Lack of Sufficient PPE for Nursing Home Staff Put Residents at Increased Risk of Harm During the COVID-19 Pandemic in Some Facilities

New York state and federal laws and guidance require nursing homes to follow infection control protocols, which include obtaining sufficient infection control supplies such as PPE to provide to staff and residents to protect them from the risk of infection from transmissible disease, including COVID-19. Science, common sense, and OAG's preliminary findings following initial COVID-19 investigations indicate that a nursing home's lack of sufficient PPE and failure to comply with CDC and DOH guidance increased the risk that COVID-19 spread to other residents and staff within the facility. Conversely, OAG's preliminary investigations indicate that residents had better health outcomes in nursing homes that had trained staff and plans in place to obtain sufficient PPE.

OAG received multiple reports that during the first wave of the pandemic, several nursing homes across the state had woefully inadequate PPE to prevent the transmission of COVID-19. OAG received allegations that due to PPE shortages, facilities violated basic infection control practices by requiring staff to re-use PPE or to clean used PPE. OAG received a report that in a for-profit facility in Western New York with CMS 2-Star Staffing and 2-Star Overall ratings, there was a lack of PPE for staff use until the first resident with suspected COVID-19 went to the hospital, and that an LPN at the facility was allegedly forced to resign after she questioned inadequate PPE policies and refused to work under conditions where staff and residents would not be safe. In early April, OAG heard from several other employees of that same nursing home who advised OAG that the staff at the facility allegedly were not provided adequate PPE for several weeks at the beginning of the pandemic and were forced to share gowns, which were kept hanging in hallways on hooks. OAG also heard that, in addition to not having adequate PPE, the facility allegedly violated basic infection control protocols by allowing communal dining, contrary to government-issued guidance, until the first resident went to the hospital in late March. Another LPN at this facility reported that she cared for a COVID-19 positive resident with only sanitizer and gloves because that was all that was available at the time and facility management told her and other staff members that they would have to make do with what they had. According to the LPN, there were not enough surgical masks to change between COVID-19 positive and negative residents and staff were instructed to make surgical masks last as many days as possible. She reported that the facility did not have N95 masks or face shields and that staff resorted to using surgical masks or homemade cloth masks, gloves, and "contaminated" shared gowns.

Regarding a for-profit nursing home in Western New York with CMS 1-Star Staffing and 2-Star Overall ratings, OAG received a report from a nurse manager that the owner of the facility directed staff not to wear masks and that it would be "business as usual" because the facility did not have sufficient PPE. This nurse manager allegedly went directly to the New York State Office of Emergency Management (OEM)[40] to attempt to obtain additional PPE for her staff. The same nurse manager reported that inexplicably her decisions were continually undermined by ownership. For example, after the nurse manager allegedly attempted to stop communal dining after CDC guidance restricting communal activities, ownership reversed her decision days later and resumed communal dining. Another RN supervisor at this facility resigned when she began to feel like continuing to work was putting her license at risk due to inadequate PPE at the facility. A CNA from this facility also reported that "masks were optional" even after visitors were barred from the facility and there was no quarantining of residents until weeks into the pandemic.

Though these reports allege that these facilities did not have adequate PPE during the first few months of the pandemic, and investigations are ongoing, OAG has been assured that each of these facilities now has an adequate supply and is appropriately distributing PPE to staff.

In another continuing investigation into a different for-profit Western New York nursing home with CMS 1-Star Staffing and 1-Star Overall ratings, OAG heard from an aide who reported that between mid-March and early April, she asked the nurse supervisor of the facility for her own gown. The nurse supervisor replied to the aide that she cannot pass out PPE "willy nilly" and that gowns were only for those "on the front line," even though the aide was very much on the front line and providing direct care to residents. The aide alleged that she was eventually given a gown but told she had to reuse it every day. She noted to OAG investigators that over time those gowns became visibly soiled, such that she and her fellow caregivers threw them out and resorted to simply wearing a regular sleeping gown over their clothes when tending to residents. Some of the aide's statements were corroborated by a funeral director who reported to OAG that when he entered the facility in mid-April to retrieve a deceased resident, he observed staff wearing PPE that was only in the forms of gowns, regular surgical masks, and gloves. He stated staff did not take his temperature when he entered the facility, nor was he asked to fill out a health questionnaire. He also stated that he observed used gloves strewn on the floor of the facility.

As widely reported in the media and confirmed by OAG in its preliminary investigations, many health care institutions faced challenges to acquire and compile sufficient PPE to meet the demands placed on institutions during the COVID-19 pandemic. PPE was most scarce during the first few months of pandemic, but ultimately became more available due to the efforts of DOH, OEM, and county and local governments. New York state also coordinated with other states and worked to secure additional PPE. During preliminary investigations, OAG learned of several facilities that had dangerously low stockpiles of PPE but received additional supplies from DOH or OEM, including two for-profit facilities in New York City, one with a CMS 2-Star Staffing rating and one with a CMS 1-Star Staffing rating, and two other facilities on Long Island, both CMS 2-Star Staffing rated facilities. DOH and OEM's provision of PPE to nursing homes helped decrease risks of infection and harm to residents in many facilities.

On February 6, DOH issued a guidance to the health care industry reminding facilities to "be ready and equipped" to "manage patients presenting to their facility with the potential of being infected with [COVID-19]." The guidance reminded institutions that shortages of PPE may occur and of the importance to strictly adhere to the latest guidance from CDC. DOH instructed all facilities to compare their existing inventories of PPE against the expected rate of use of these items under a surge situation and to determine the quantities needed to be on hand. Facilities that identified a shortage of PPE were directed to use existing vendors and to activate mutual aid agreements to obtain available support if needed. If the facility was unable to obtain needed PPE from those sources, facilities were instructed to notify their local emergency management agency, DOH or, if necessary, OEM. OAG observed that many facilities that had dangerously low inventories of PPE ultimately received PPE from either DOH, OEM, their local government, or other sources, including donations from the public. On April 2, DOH issued another advisory to the health care industry noting that New York state continued to fulfill requests for PPE, as available, and that health care entities should continue to submit requests for PPE through their local emergency management agency.

OAG observed that many institutions were making good faith efforts to purchase sufficient PPE but were hampered by several external factors, including supply chain issues. OAG's preliminary findings appear to show that many nursing homes, consistent with their obligation to ensure emergency preparedness, made admirable efforts to get needed PPE in time to protect residents and health care workers. At the same time, timing and expenditure levels of effort and funds made by nursing homes to obtain PPE appear to have varied. OAG will continue to investigate whether those facilities that failed to obtain adequate supplies of PPE made good faith, but ultimately unsuccessful, efforts or whether facilities that failed to provide PPE to their staff and their residents did so due to their lack of responsible planning, their refusal to purchase critically needed PPE through available vendors, or similar conduct relating to their operations.

D. Lack of COVID-19 Testing for Residents and Staff in Early Stages of the Pandemic Put Residents at Increased Risk of Harm in Many Facilities

During a pandemic, the federal government plays a key role in the ability of states' access to testing for new viruses. In February, CDC's work to develop the first COVID-19 test failed, resulting in a critical delay of several weeks before CDC developed an effective test. By the time CDC sent the new test kits out to the states, COVID-19 had spread within the United States, including to New York. Afterward, CDC encouraged the Food and Drug Administration (FDA) to allow hospitals and commercial labs to produce tests for sale faster. Additional delays occurred when the FDA took weeks to begin issuing emergency authorizations for other tests.

In March, COVID-19 testing capacity in New York state was limited. New York state agencies took action that helped protect nursing home residents, including working to obtain the ability within the state to conduct increased COVID-19 testing. At the same time, OAG's preliminary investigations indicate that nursing homes had varying degrees of access to COVID-19 testing early in the pandemic, with many lacking access to sufficient testing in March and April. Some facilities reported that once receiving test kits, the turnaround time on test results was lengthy. One facility reported that it transferred patients to the hospital because there was no other means to get testing.

After testing became increasingly available, Governor Cuomo issued an executive order requiring COVID-19 testing by nursing homes of their staff, which helped protect residents from the risk of infection and harm. DOH tested nursing home residents at various facilities, which also helped protect residents.

While testing of staff is now regular and mandatory, and testing availability has improved significantly, the preliminary investigations reflect insufficient availability of COVID-19 testing for residents and staff of nursing homes in the early stages of the pandemic. The lack of testing increased the risk of COVID-19 infection of residents and staff. If residents and staff are not tested for COVID-19, they may be infected yet asymptomatic, and unknowingly transmit the virus to others through informal contact when they otherwise would be isolated or quarantined under CDC guidance. In addition, a lack of readily available testing for residents and staff also can hinder their ability to obtain prompt and specific medical treatment for those who become symptomatic and ill.

DOH guidance issued on March 21 directed downstate nursing homes, which were in areas of high community-based transmission, to treat all residents who exhibited COVID-19 symptoms as if they had been diagnosed with COVID-19 for purposes of infection control protocols. However, if a nursing home lacked access to testing, it is possible that asymptomatic residents who were not tested and who were unable to communicate symptoms they were experiencing might not be readily apparent to staff for a period of time before symptoms were identified. Under those circumstances, those residents are at greater risk of harm from not receiving treatment and/or close monitoring for changes in condition. In addition, the circumstances create an increased risk of transmission to others in the facility.

For example, OAG received a credible allegation from the daughter of an asymptomatic nursing home resident about a for-profit upstate facility with CMS 2-Star Staffing and 1-Star Overall ratings. She alleged that the facility responded that due to the limited number of test kits at the facility, it could only test her father if he exhibited symptoms. He later exhibited symptoms, including a high fever, and was sent to the hospital where he tested positive for COVID-19.

OAG's preliminary investigations also provide anecdotal support that staff infected with COVID-19 in certain instances worked within nursing homes during periods that they were undiagnosed and asymptomatic, thereby increasing the risk of infection and harm to residents. CDC guidance provides that when a health care provider is infected with COVID-19, "Anyone who had prolonged close contact (within 6 feet for at least 15 minutes) with the infected health care provider might have been exposed." CDC guidance also states that "if the provider had COVID-19 symptoms, the provider is considered potentially infectious beginning 2 days before symptoms first appeared." If the provider was asymptomatic and the date of exposure to COVID-19 infection can be identified, the provider should be considered potentially infectious beginning 2 days after the exposure. CDC guidance also states that the infectious period for COVID-19 is generally accepted to be 10 days after onset of the infection.

As one example, in a large not-for-profit nursing home in New York City with CMS 2-Star Staffing and 3-Star Overall ratings, a facility manager indicated that an experienced LPN worked on a unit with over 40 residents until March 14, when he stopped working, was diagnosed with COVID-19, and later died. By March 21, the facility reported 20 percent of its staff were out sick. The facility reported no COVID-19 resident deaths up to that date. From March 22 to March 29, the facility reported seven COVID-19 resident deaths, including two within the facility and five after transfer to the hospital. From March 29 to April 4, the facility reported 26 COVID-19 resident deaths, including 18 within the facility and eight after transfer to the hospital. The facility management stated that in early stages of the pandemic, DOH's Wadsworth lab was the only lab doing COVID-19 testing, and then others started, including the facility's own lab. In April, the facility stated that getting COVID-19 test results took 36 hours.

More nursing homes tested residents in April and May as testing capacity increased in the state, including in the months that followed.

1. Testing Requirements Helped Facilities Identify Residents and Staff Who Were Infected with COVID-19

Governor Cuomo issued Executive Order 202.19 on May 17 for DOH to establish a "statewide coordinated testing prioritization process" for all laboratories in the state, both public and private, for conducting COVID-19 diagnostic testing. Executive Order 202.30, issued May 10, required nursing homes to test full time staff twice a week for COVID-19.[41] These measures, along with the increased testing capacity, helped facilities identify residents and staff who were infected with COVID-19 and decrease the risk of transmission of infection and illness to nursing home residents and staff. Testing staff enables facilities to identify asymptomatic individuals who can then quarantine until they can safely return to work to provide care to residents. Testing residents enables facilities to identify asymptomatic individuals who can then remain isolated from non-infected residents. A lack of testing of health care workers who are at risk of COVID-19 infection increases the risk of transmission to residents when COVID-19 is present in the surrounding community.

OAG's investigations indicate that, absent Executive Order 202.30, many staff would not have been tested by the nursing homes. For example, one for-profit upstate nursing home with CMS 1-Star Staffing and 1-Star Overall ratings referred its staff to their primary physicians[42] to obtain COVID-19 testing in the earlier stages of the pandemic. However, the facility reported that after COVID-19 testing was required, it tested staff weekly. Similarly, a for-profit nursing home in New York City with CMS 1-Star Staffing and 3-Star Overall ratings reported that it had started testing residents in late March. The facility also reported that staff were tested, and that after Executive Order 202.30 providing testing guidelines, they were adhering to them.

This, and other information, indicates that absent an obligation to test staff, many nursing homes would not have tested staff for COVID-19, and many staff could not have obtained testing frequently on their own, unless testing was otherwise easily available and free.

2. DOH Testing Protected Residents

The preliminary investigations reflect that DOH tested many residents and staff at nursing homes later in the pandemic. For example, at a for-profit nursing home in New York City with CMS 2-Star Staffing and 1-Star Overall ratings, the administrator indicated that DOH provided facility testing and more PPE, and tested the entire facility, including residents and staff. Similarly, a for-profit facility in Western New York with CMS 2-Star Staffing and 2-Star Overall ratings that had reported a lack of testing ability, stated that its testing issues had been resolved through apparent facility-wide testing conducted by DOH. Relatively shortly thereafter, the facility reported it was COVID-free.

E. Lack of Nursing Home Compliance with Executive Order Requiring Communications with Family Members Caused Avoidable Pain and Distress

OAG took immediate and direct action with respect to a number of facilities regarding communication with family members. The most formal actions consisted of written warnings and cease & desist notices. Most communication issues were rapidly solved with less formal contact by OAG staffers with the facility and/or families. Three facilities were given such formal warnings, and ten facilities were advised orally that there was credible information that they were failing to comply with executive orders and action would be taken if not promptly resolved. (As noted elsewhere, roughly half of the intakes involved allegations of further or other problems at facilities.)

F. Government Issued Guidance May Have Led to an Increased Risk to Residents in Some Facilities and May Have Obscured the Data Available to Assess the Risk

While government-issued guidance from CDC and DOH based on updated information relating to COVID-19 helped protect many New York residents, nursing home implementation of some guidance may have led to an increase risk of fatalities in some facilities and may have obscured data reported by nursing homes.

1. At Least 4,000 Nursing Home Residents Died After DOH's March 25 Guidance on Admission Practices

On March 25, DOH issued guidance providing that "[n]o resident shall be denied re-admission or admission to the nursing home solely based on a confirmed or suspected diagnosis of COVID-19. Nursing homes are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or re-admission."[43] The guidance was rescinded on May 10 in Executive Order 202.30. From March 25 to May 8, 6,326 hospital patients were admitted to 310 nursing homes. The peak of these admissions was the week of April 14.[44] The peak single day in reported resident COVID-19 deaths was April 8, with 4,000 reported deaths occurring after that date.

Many nursing home industry and other commentators have criticized DOH's March 25 guidance as a directive that nursing homes had to accept COVID-19 patients who were infectious.[45] At the same time, the March 25 guidance was consistent with the CMS guidance on March 4 that said nursing homes should accept residents they would have normally admitted, even if from a hospital with COVID-19, and that patients from hospitals can be transferred to nursing homes if the nursing homes have the ability to adhere to infection prevention and control recommendations. It was also consistent with CDC Published Transmission-Based Precaution (T-BP) guidance, which was referred to in CMS's March 4 guidance, and which stated that if T-BP were still required for a patient being discharged to a nursing home, the patient should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with COVID-19. *See* Appendix A.

It is worth noting that to the extent New York hospitals had capacity concerns due to the pandemic, the March 25 guidance would have been helpful to communities where those facilities were experiencing longer COVID-19 patient stays due to delays in receiving testing results, and were at or exceeding acute care capacity while they simultaneously were anticipating more new patients in need of acute care.[46] This is because many hospitals in areas of high COVID-19 infection rates in some other states reported that "post-acute facilities were requiring negative COVID-19 tests before accepting patients discharged from hospitals."[47] This practice meant that some patients who no longer required acute care were occupying valuable hospital beds while waiting to be discharged.[48]

DOH has said that nothing in the guidance stated that a facility should accept patients who could not be safely cared for. As to whether the March 25 guidance affected risks to residents, DOH presented data[49] reflecting the spike in health care worker infection and the later spike in deaths as circumstantial support for the position that the guidance did not contribute much to resident risks or deaths. Criticism since then notes that there has been no presentation of additional evidence as to whether the admission of patients from hospitals to nursing homes may have contributed to COVID-19 transmission or COVID-19 related deaths of nursing home residents. DOH states CDC says COVID-19 positive patients cannot likely transmit the virus after nine days of infection, and that patients are most infectious within two days after symptoms appear.[50] CDC guidance also says there is uncertainty on this. DOH says the median hospital stay was nine days.

Data linking the number of nursing home deaths to the admissions policy contained in the March 25 guidance is obscured by that same guidance, which also prohibited nursing homes from requiring COVID-19 testing as a criterion for admission. This phenomenon was compounded by both the March 21 directive that largely paused the testing of downstate residents, and the under-reporting of nursing home deaths generally (as previously discussed). OAG's investigation to date has not revealed an admission from any nursing home operator that they could not care for referred residents. However, using the DOH publicized data, over 4,000 nursing home deaths occurred after the issuance of the March 25 guidance.[51] While additional data and analysis would be required to ascertain the effect of such admissions in individual facilities, these admissions may have contributed to increased risk of nursing home resident infection, and subsequent fatalities (whether due to actual transmission of infection from new residents to incumbent residents, or due to the facilities' poor self-assessment during the admission process that was followed by failure to provide appropriate care to that patient or other residents.)

2. DOH's March 21 Guidance on Testing Practices Obscured the Data

As previously discussed, OAG's preliminary investigations reflect that COVID-19 testing availability for nursing homes downstate was limited in March and April, and fraught with delays. In this context, OAG preliminary investigations reflected that in the nine downstate counties that experienced higher community-based transmission of COVID-19, some facilities stopped testing residents for COVID-19 after the March 21 guidance was issued. For example, the administrator of a for-profit facility in New York City with CMS 1-Star Staffing and 1-Star Overall ratings alleged in April that the facility was not currently testing residents for COVID-19. He alleged that DOH told the facility to stop testing at some point in March. He alleged that prior to that, the facility was conducting testing through a lab. Similarly, the administration of a for-profit facility on Long Island with CMS 3-Star Staffing and 2-Star Overall ratings alleged that the facility originally tested seven residents and had suspended the testing of residents following the DOH "directive" that tests were not required. The facility alleged that it understood that all parties should be considered infected and treated as such. A for-profit facility in New York City with CMS 3-Star Staffing and 2-Star Overall ratings alleged that while it did not have access to COVID-19 testing, it was relying on DOH guidance issued March 21 for not testing.

G. Immunity Provisions May Have Allowed Facilities to Make Financially-Motivated Decisions

Due to several recent changes in law, it is unclear to what extent facilities or individuals can be held accountable if found to have failed appropriately to protect the residents in their care. On March 23, Governor Cuomo issued Executive Order 202.10, which created limited immunity provisions for health care providers relating to COVID-19.

The specific statute, the Emergency Disaster Treatment Protection Act (EDTPA), was enacted on April 6, and provides immunity to health care professionals from potential liability arising from certain decisions, actions and/or omissions related to the care of individuals during the COVID-19 pandemic retroactive to Governor Cuomo's initial emergency declaration on March 7. The legislation created a new Article 30-D of the Public Health Law. The legislature noted that the purpose of the EDTPA was to "promote the public health, safety and welfare of all citizens by broadly protecting the health care facilities and health care professionals in this state from liability that may result from treatment of individuals with COVID-19 under conditions resulting from circumstances associated with the public health emergency."[52]

The original form of the EDTPA,[53] in effect during the time period of this report, provided that:

> *Any health care facility or health care professional shall have immunity from any liability, civil or criminal, for any harm or damages alleged to have been sustained as a result of an act or omission in the course of providing health care services, if: (a) the health care facility or health care professional was providing health care services in accordance with applicable law, or where appropriate pursuant to a COVID-19 emergency rule; (b) 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, (c) the health care facility or health care professional is providing health care services in good faith.*[54]

There is an exception, but it comes with a potential loophole:

> "[Immunity] shall not apply if the harm or damages were caused by an act or omission constituting willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm. . . *provided, however, that acts, omissions or decisions resulting from a resource or staffing shortage* [emphasis added] shall not be considered to be willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm."[55]

The EDTPA is silent as to whether the safe-harbor for "resource or staffing shortage" is to be assessed only based on conditions that arose as a result of the COVID-19 emergency or whether it intended to include such shortages existing prior to the emergency period. As seen in this report, pre-pandemic staffing shortages are associated with deaths from COVID-19. Therefore, the question of the scope of immunity is important in determining remedies.

To the extent that the executive order and/or EDTPA were interpreted by any nursing homes as providing blanket immunity for harm to residents other than intentional harm, even if the harm was related to intentional resource and staffing allocations, Attorney General James disagrees with such an interpretation as illogical, contrary to public policy, and contrary to the law's intent. The intent was to support health care professionals making impossible health care decisions in good faith during this unprecedented crisis. As exemplified in subsections below, the preliminary investigations illustrate instances of facility decisions that relate to or affect resident care that are financially motivated, rather than clinically motivated. OAG investigations will continue as to acts both prior to, and after, the August 3 amendments to Public Health Law Article 30-D.

Admissions Decisions and Staffing Decisions: A facility's decision to admit new residents is also a staffing decision because it requires a facility to assess whether its staffing level is sufficient to provide care to meet the needs of the existing residents and any proposed new residents. When a for-profit nursing home has an empty bed, it has a financial motivation to increase its census by admitting residents in order to obtain the daily rate of reimbursement offered by the resident's payor – Medicaid, Medicare, other federal health insurance, or private insurance.[56]

During the pandemic, many facilities experienced empty beds as residents died from COVID-19 or other causes. Some families took their loved ones to a family member's home. A decrease statewide in elective surgeries at hospitals reportedly stopped a regular flow of patients to nursing homes for rehabilitation. As discussed above, many facilities also experienced staffing reductions due to COVID-19 illness and quarantine, which necessarily decreased the facility's capacity to provide care for its residents, and, as the examples discussed herein reflect, resulted in exacerbated staffing problems.

The preliminary investigations indicate that nursing homes took a variety of approaches to decisions to admit residents during the COVID-19 pandemic, even as they were experiencing staffing shortages due to staff illness from, or otherwise inability to work due to, COVID-19. The approaches suggest admissions decisions were affected to varying degrees by financial motives, and by clinical and administrative evaluations of the facility's ability to provide appropriate care to its residents. OAG received information during its investigations that some facilities decided that the safest course was to stop admitting residents for periods of time while their staffing was low. For example, a not-for-profit nursing home in New York City with CMS 2-Star Staffing and 3-Star Overall ratings that experienced staffing shortages due to COVID-19 infection reported that it stopped admissions on March 21 due to 20 percent of staff calling in sick. In addition, to improve staffing, the facility brought in agency staff home health aides and restructured the staff.

In contrast, a for-profit nursing home in Western New York with CMS 1-Star Staffing and 1-Star Overall ratings indicated it took a different approach to admissions. Managers at that facility alleged that as of the end of April, the facility continued to accept new residents despite ongoing staffing difficulties, having nine out of 126 residents who tested positive for COVID-19, five residents dying from confirmed COVID-19, and five staff testing positive for COVID-19.

A for-profit facility in Western New York with CMS 2-Star Staffing and 2-Star Overall ratings indicated it also accepted new patients in April, but only admitted residents if they had recovered from COVID-19. However, as of April 30, according to a nurse supervisor, the facility was not taking admissions for at least a week due to the "state of the facility." The investigation reflected that the "state of the facility" included unstable conditions as alleged by staff:

» A high rate of COVID-19 positive cases, with 33 out of 59 residents testing positive;

» The facility had tested less than half of the residents;

» The facility did not have enough tests to test the remaining residents, and was trying to get more;

» 14 positive staff members and 12 more pending staff tests;

» Staffing shortages;

» The facility administrator was out sick.

As of mid-May, the nurse supervisor asserted that staffing had improved, with most staff who were out sick or quarantined returning to work. As of the following week, the acting administrator advised that staffing issues were continuing to improve, testing issues had been resolved, and facility had been COVID-19 free for two weeks, and facility expected to be taken "off precautions" from DOH shortly. The facility provided documentation indicating it had passed DOH infection control surveys in early May and mid-May.

Financial Incentives Illustration — Admissions: As illustrated in the example below, the preliminary investigations reflect how the financial incentives within the current system resulted in pressure by some for-profit owners to push staff to admit increased numbers of residents from hospitals in order to reach census goals, regardless of whether the facility had sufficient staff to care for them. Specifically, in one for-profit facility in New York City with CMS 2-Star Staffing and 1-Star Overall ratings, an administrator reported communications with an owner about hospital admissions. The facility interpreted DOH's March 25 guidance not to deny admission of residents from the hospital solely on the basis of a COVID-19 positive diagnosis as "they were to admit COVID-19 residents from the hospital." The facility admitted five hospital patients on March 26, but the owners wanted to admit more. The administrator alleged that there were arguments with the owners over how many residents they could safely care for. According to the administrator, every new admission from the hospital was a patient who was "COVID positive."[57]

Incentive Pay and Bonuses to Staff: Preliminary investigative findings also reflected a range of sizes of financial investment that facilities and/or owners were willing to make for short periods of time during the pandemic to provide monetary incentives to health care workers in order to retain staff, to attract new staff as full-time employees or as temporary agency staff, and to encourage staff to work additional shifts at the facility. Facilities' reported choices in providing financial incentives to increase staffing reflect different perspectives on what level of expenses were determined to be necessary versus optional. Some facilities paid small bonuses to staff for each additional shift they took, with some limiting the bonus to shifts involving work with COVID-19 positive residents. Other facilities paid generous salary increases per hour for hazard pay. Still other facilities paid staff both salary increases and bonuses per extra shift worked. Some offered hazard pay for a few weeks, while others offered it for longer periods of time. Some paid agency staff extra, while others did not.

H. Ongoing Investigative Work

Following the first wave of COVID-19 in New York, OAG has continued to conduct in-depth investigations involving the COVID-19 impact at over 20 facilities, and to monitor and follow up as needed with the facilities that were the subject of initial investigations. During this time, OAG has received new allegations of neglect and abuse connected with COVID-19 conditions, as well as reports of neglect and abuse of nursing home residents seemingly unrelated to COVID-19, and conducted additional investigative work. OAG continues to investigate and to find and follow the facts in order to serve its mission to protect nursing home residents from abuse and neglect, and to protect Medicaid from provider fraud. OAG will continue these investigations, without fear or favor, and make recommendations regarding remedies, when and where appropriate.

COVID-19 is continuing to spread from person to person throughout our communities, bringing more illness and untimely death in our state, as well as in our nation and our world. This preliminary report serves to increase transparency and awareness of preliminary findings from the first wave in New York state, including the conditions and risks that many nursing home residents faced. This information will help to identify challenges we face together and potential solutions, and to encourage collective action by our state's residents to protect each other, and our state's vulnerable nursing home residents. The recent advent of the COVID-19 vaccine is a welcome development that will help save lives as it is distributed, providing additional protection to health care workers, nursing home residents, and, eventually, everyone. At the same time, it is not a panacea. More action is needed to protect nursing home residents, and to provide them with the care and dignity that they deserve while living in the skilled nursing facilities that are their homes.

Regulatory Framework

A. New York State Law on Nursing Home Requirements to Provide Care and Staffing to Meet Resident Needs

New York law explicitly recognizes that for the vast majority of nursing home residents, "the nursing home will be their last home." Accordingly, a license to operate a nursing home carries with it "a special obligation to the residents who depend upon the facility to meet every basic human need."[58] New York law recognizes that "*nursing homes should be viewed as homes as much as medical institutions* [emphasis added]."[59] Each nursing home is required to give each resident "the appropriate treatment and services to maintain or improve his or her abilities" and provide each resident with "the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care subject to the resident's right of self-determination."[60] A nursing home is required to "accept and retain only those residents for whom it can provide adequate care."[61]

New York state's current minimum nursing home staffing standards require one RN for eight consecutive hours every day of the week, plus one RN or one LPN as a "Charge Nurse" 24/7 (or one charge nurse for each unit or "proximate" units for each tour of duty). This is proximate to the federal Medicaid/Medicare minimum standard. A facility must have a full-time employee RN as director of nursing who counts towards the staffing formula.

New York law requires nursing homes to provide "sufficient nursing staff and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being."[62] State law also provides that homes, in conjunction with a physician, describe each resident's needs in a "Comprehensive Care Plan," which identifies health concerns and directs particular courses of treatment, specifying, among other things, medications, assisted movement, skin care, bowel and bladder care, and nutrition needs.[63]

B. New York State Law on Nursing Home Duties to Residents

Nursing home residents in New York have basic protections and legal rights to ensure that they are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside the facility.[64] Among those rights are adequate and appropriate medical care, and the right to be fully informed by a physician in a language that the resident can understand, using an interpreter when necessary, of their total health status, including but not limited to, their medical condition including diagnosis, prognosis, and treatment plan. Each resident or their representative has the right to ask questions and have them answered, be fully informed in advance about care and treatment, and of any changes in that care or treatment that may affect the resident's well-being.

Each nursing home has a legal obligation to communicate important information to the resident or the resident's representative. Every resident has the right to name an agent or "health care proxy" to act as their designated representative. The designated representative shall receive any written and oral information required to be provided to the resident and participate in decisions regarding the care, treatment and well-being of the resident if such resident lacks the capacity to make such decisions.[65] Each facility is required (except in a medical emergency) to notify the resident's physician and designated representative within 24 hours when there is an accident involving the resident, which results in injury requiring professional intervention; a significant improvement or decline in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.

C. Federal Law on Nursing Homes

Nursing homes must comply with certain requirements under federal statutes and regulations in order to participate in the Medicare and Medicaid programs.[66] The Nursing Home Reform Act, updated in 2016, contains a broad mandate that nursing homes "must provide [each resident with] the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care."[67] The law also prioritizes individualization of care plans and the primacy of resident autonomy and choice.[68] The regulation states that "[a] facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality."[69] Following this aim, residents have the right to: participate in their treatment; receive all services included in their plan of care; be free from any physical or chemical restraints that are not required to treat medical symptoms and are imposed for purposes of discipline or convenience; express grievances and have them addressed; and, engage in choice (as to activities, schedules, visitors, etc.).[70] Residents also have the right to be free from abuse, neglect, misappropriation of property and exploitation, and the facility must ensure these resident rights are upheld and report any instances where these rights have allegedly been violated to applicable state officials.[71]

Nursing homes are also specifically required to ensure residents "[m]aintain[] acceptable parameters of nutritional status, such as usual body weight" and receive "sufficient fluid intake to maintain [their] proper hydration and health."[72] Nursing homes must also develop personalized plans of care for each resident and conduct periodic assessments of each resident, at which point personal plans are "reviewed and revised."[73] The goals of the resident are also to be included in their personal care plans, and the complete interdisciplinary care team must help prepare the care plan, including the resident's attending physician, registered nurse, nurse aid, and a nutrition staff member.[74]

Nursing homes must also provide necessary services "to ensure that a resident's abilities in activities of daily living do not diminish" unnecessarily.[75] This means the facility must give residents the appropriate treatments and services so that residents can perform daily living activities (*e.g.*, personal hygiene, mobility, dining, communication) on their own. For those residents who are unable to accomplish daily living activities on their own, the facility must provide services to maintain good nutrition, grooming, and hygiene.[76] In addition, nursing homes must ensure an ongoing program of both group and individual activities based on each resident's care plan, that ensures the "well-being of each resident, [and] encourage[s] both independence and interaction in the community."[77]

Every resident must be in the care of a physician who must visit them once every 60 days and more often in the first three months of a resident's stay.[78] Nursing homes must also have "sufficient nursing staff with the appropriate competencies and skills sets…to assure resident safety" and the total "well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population."[79] Each facility must also employ sufficient staff for food and nutrition services, and the staff must possess appropriate competencies "taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population."[80]

Among other things, facilities must also provide or obtain dental services, laboratory services, radiology services, and other diagnostic services to meet residents' needs.[81] Similarly, residents requiring physical therapy, speech-language pathology, occupational therapy and/or rehabilitative services for mental disorders and intellectual disability, must be provided with such services.[82] Facilities must also "operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility."[83] The facilities must comply with all HHS regulations, including those relating to nondiscrimination, confidentiality of health information, fraud, and abuse.[84] Operationally, they must maintain medical records containing residents' assessments, care plans, diagnostic results, and other progress notes.[85] They must also develop a quality assurance and performance improvement (QAPI) program that collects and reviews data, as well as resident and staff complaints, in order to facilitate facility improvement.[86] They are required to have a compliance program to prevent and detect criminal, civil, and administrative violations, and promote quality of care.[87]

1. Federal Law for Nursing Homes Especially Pertinent to the COVID-19 Pandemic

Some federal requirements are very pertinent in the COVID-19 pandemic. Nursing homes must conduct "a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies." The assessment must be updated at least annually and whenever there is a "change that would require a substantial modification to any part of this assessment."[88] Additionally, nursing homes must develop, maintain and update an emergency preparedness plan. This plan must be a "facility-based and community-based risk assessment, utilizing an all-hazards approach."[89] They must complete annual emergency preparedness training based on their plan.[90]

The regulations also require facilities to have an infection prevention and control program "to help prevent the development and transmission of communicable diseases and infections."[91] The program must include "a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services;" and "precautions to be followed to prevent spread of infections."[92] The plan must be reviewed annually and updated as necessary and the facility must hire an infection preventionist who is responsible for the infection control plan.[93] Finally, the regulation outlining infection control was updated on May 8, 2020 to include specific reporting and communication requirements relating to COVID-19.[94]

2.2019 Changes to Federal Nursing Home Regulations

In 2019, CMS made changes to nursing home regulations, including the elimination of the ban on binding arbitration agreements between facilities and residents. In July 2019, CMS rolled back regulations that had prohibited pre-dispute arbitration agreements between facilities and residents. Under the new rules, facilities are able to enter into binding arbitration agreements with residents at any point prior to a dispute, including prior to the resident living in the facility.[95] This change means that many residents will not have the ability to sue their facilities in court. It also shields nursing homes from legal accountability for their actions.

3.CMS's 2019 Proposed Changes to Nursing Home Regulations

In July 2019, CMS proposed sweeping changes to long-term care facility regulations, citing an interest in minimizing facilities' obligations.[96] Attorney General James submitted comments objecting to this proposal, urging CMS to prioritize resident well-being and facility accountability. Some of the regulations, especially a proposal to lessen infection control requirements, likely would have caused more resident morbidity and mortality had they been finalized before the COVID-19 pandemic. Some of the proposed changes that are most pertinent to the COVID-19 pandemic are described below.

Reducing Infection Control Requirements: CMS's proposed regulations would change infection preventionists' required work duration from "at least part time" to "sufficient time … to meet the objective's [sic] set forth in the facility's [infection prevention and control program]."[97] CMS correctly noted in its proposal that infection is the leading cause of morbidity and mortality in nursing homes, yet still made this proposal to alleviate "excessive administrative burden."[98] The ongoing pandemic and mounting toll of COVID-19 resident deaths nationwide underscore the importance of more stringent infection control protections.

Decreasing Frequency of Facility Assessments: The existing regulations require facilities to conduct an annual facility assessment to determine what resources are needed to care for residents in the ordinary course, and in emergencies. The 2019 proposed rule relaxes the current annual safety assessment requirement and replaces it with the need for the facility to conduct such assessments only biennially.[99] Decreasing the frequency of the assessment would allow safety hazards to go unnoticed, changes in staffing and resident populations to remain unconsidered, and evolving resident health acuity and morbidity to continue unaddressed.

Reducing Requirements of Quality Improvement Programs: CMS's 2019 proposed rules also remove most of the elements required for QAPI programs.[100] The effect of this is to render the proposed regulation too vague to be useful. CMS justifies deleting the QAPI required elements by stating, "the level of specificity and detail in the QAPI requirements... may limit a facility's ability to design their QAPI program to fit their individual needs."[101] However, the required QAPI elements are all broad and leave plenty of room for facility customization of their QAPI plans.

Reducing Public Transparency: Current CMS guidance is that facility compliance survey results should not be included in the Certification and Survey Provider Enhanced Reports (CASPER) system before the conclusion of any informal dispute resolution, which prevents the results from being incorporated in facilities' CMS Quality Measures rating. CMS proposes to incorporate this guidance as a new regulation.[102]

Removing Residents' Rights-Medical Providers: CMS proposed to only provide residents with their primary physician's name and contact information, removing the current requirement that facilities ensure residents remain informed of the names of all primary care professionals involved in their care.[103] The proposed change would make it difficult for patients to learn about and make changes to their broader medical team and services, and in some cases, effectively prevent them from exercising any control over their medical team and services.

Removing Residents' Rights-Grievance Process: The proposed regulations contain a provision that distinguishes between resident "feedback" and resident "grievances" and suggests different treatment for each, at the expense of residents' rights.[104] With facilities' power to determine the definition of a "grievance," they are also empowered to determine which complaints will undergo a full grievance investigation. This proposed change would likely result in a lack of accountability for facilities and a corresponding lack of support for residents.

Decreasing Review of Anti-Psychotic Drug Prescriptions: The proposed regulations remove the requirement that Pro re Nata (PRN or "as needed") prescriptions for anti-psychotic drugs can only be renewed after the physician re-evaluates the patient for the drug's continued appropriateness.[105] This proposal removes vital patient protections. Given the past abuse of these drugs as a means of physical control of residents and their potential danger, a close monitoring of anti-psychotic prescriptions must remain in place. Evidence shows that antipsychotics are associated with increased cerebrovascular morbidity and mortality among patients with dementia. Multiple government agencies and medical associations have taken notice of the overprescribing of antipsychotics to nursing home residents with dementia. Removing review requirements for anti-psychotic drug prescriptions places patients at health risk that might be further exacerbated during a pandemic.

Recommendations

Ensure public reporting by each nursing home as to the number of COVID-19 deaths of residents occurring at the facility — and those that occur during or after hospitalization of the residents — in a manner that avoids creating a double-counting of resident deaths at hospitals in reported state COVID-19 death statistics.

As detailed in the report, discrepancies remain over the number of New York nursing home residents who died of COVID-19. Data obtained by OAG shows that DOH publicized data vastly undercounted these deaths. Ensuring standardized public reporting will alleviate these discrepancies and provide needed transparency.

Enforce, without exception, New York state law requiring nursing homes to provide adequate care and treatment of nursing home residents during times of emergency.

As detailed in the report, too many nursing home residents did not receive the adequate care and treatment to which they are entitled. While the COVID-19 pandemic put undue stress on many of our nation's systems, nursing homes must be prepared for these types of outbreaks.

Require nursing homes to comply with labor practices that prevent nursing homes from pressuring employees to work while they have COVID-19 infection or symptoms, while ensuring nursing homes obtain and provide adequate staffing levels to care for residents' needs.

There were too many instances of employees being pressured to work while contagious to ensure higher staffing levels. This put all residents and employees of the nursing home at risk. Employees should be encouraged to promptly report to DOH and OAG when owners or managers require, encourage, or knowingly permit staff to work when they are have a COVID-19 diagnosis or symptoms.

Require direct care and supervision staffing levels that: (1) are expressed in ratios of residents to RNs, LPNs, and CNAs; (2) require calculation of sufficiency that includes adjustment based on average resident acuity; (3) are above the current level reflected at facilities with low CMS Staffing ratings; and, (4) are sufficient to care for the facility's residents' needs reflected in their care plans.

Before considering any increases in Medicaid reimbursement rates to nursing homes, the state should require specified direct care and supervision staffing levels above the current level reflected at facilities with low CMS Staffing ratings and that are sufficient to care for residents' needs, and enact effective laws and regulations requiring nursing homes to provide complete disclosure of all monies transferred to related parties and the salaries, compensation, and distributions made to their owners, officers, directors and investors, and all loans made to and from any nursing home, and the repayment thereof.

Most states' standards include minimum levels for both total nursing hours and staffing levels in specific categories, without reference to the staffer's experience, familiarity with the residents or consistency of care. For example, the California standard is 3.2 hours per resident per day (HPRD) of total nursing care. Vermont requires 3 HPRD of total nursing care including an average of 2 HPRD of CNA care. Ohio requires average total care of at least 2.75 HPRD, including 0.2 HPRD of RN care and 2 HPRD of nurse aide care. Some states mix these requirements with other ratios (e.g., 1:15 staff to patient ratio) or include other staff hours (e.g., nutritionists, physical therapists). New Jersey recently enacted a minimum staffing law that requires, among other things, one CNA per eight residents (day shift); one direct caregiver per 10 residents (evening); one caregiver per 14 residents (night).

Changes in regulations regarding staffing should also address different categories of caregivers, each of which provide a different kind of care, and that accounts for the caregivers' experience and familiarity with the residents, on a 24/7 basis.

Require additional and enforceable transparency in the operation of for-profit nursing homes, including financial transactions and financial relationships between nursing home operators and related parties, and relatives of all individual owners and officers of such entities with contractual or investor relationships with the nursing home. Through a variety of related party transactions and relationships, owners and investors of for-profit nursing homes can exert control over the facility's operations in a manner that extracts significant profit for them, while leaving the facility with insufficient staffing and resources to provide the care that residents deserve.

Through a variety of related party transactions and relationships — including between owners, investors, corporate parents, landlords, purported management companies, consultants, vendors, service provider, charities and owner's family members,— owners and investors of for-profit nursing homes can exert control over the facility's operations in a manner that extracts significant profit for them, while leaving the facility with insufficient staffing and resources to provide the care that residents deserve.[106]

Before providing any supplemental funding to nursing homes, the state should require transparency, accountability and complete disclosure of the disposition of all funds received by the facilities. As a condition of payment of public funds to the nursing homes, the state should also require operators to execute monthly certifications affirming that staffing is sufficient to meet residents' needs.

Ensure that nursing homes invest sufficiently in effective training so staff can fully comply with infection control protocols. Hold operators accountable for failures to have clinically appropriate policies in place and to effectively train staff to comply with them.

Clearly, some facilities were not prepared to handle outbreaks through early and effective training or staffing. Rising COVID-19 infection rates in multiple areas of the state and a concerning number of nursing homes within those communities underscore the need for effective training in infection control protocols.

Support manufacturing of PPE to facilitate sufficient supply of PPE for purchase by nursing homes. Enforce requirements that nursing homes have sufficient inventory of PPE for all staff to be able to follow infection control protocols.

Many nursing homes severely lacked PPE for workers. In some instances, nursing home owners forewent infection control protocols, telling staff that masks and other PPE were not mandatory because they did not have enough supplies. In other cases, re-use of PPE may have contributed to the spread of infection. Nursing homes should be required to have a sufficient inventory of PPE in case of a future outbreak.

Ensure that adequate COVID-19 testing is available to nursing home residents and employees and require nursing homes to test residents and staff in accordance with CDC and DOH evidence-based guidelines.

Insufficient testing in the early days of the pandemic undoubtedly led to spread of COVID-19 by asymptomatic patients and staff. With regular testing for residents and employees, nursing homes will be much better able to contain future COVID-19 outbreaks.

Eliminate the recently enacted immunity provisions that can provide financial incentives to for-profit nursing home operators to put residents at risk of harm by refraining from investing public funds to obtain sufficient staffing to meet residents' care needs, to purchase sufficient PPE for staff, and to provide effective training to staff to comply with infection control protocols during pandemics and other public health emergencies.

The state's immunity laws were designed to provide necessary protection to frontline health care workers who placed their lives on the line during the pandemic, managers who are faced with impossible choices in caring for patients with COVID-19 in circumstances that are not of their own making, and facilities whose processes led to those decisions in good faith. These circumstances can include shortages of ventilators, respirators, medicine, other equipment, or available beds or services. As written, the immunity laws could be wrongly used to provide any individual or entity from liability, even if those decision were not made in good faith or motivated by financial incentives.

Formally enact and continue to enforce regulatory requirements that nursing homes communicate with family members of residents promptly, but not later than within 24 hours, of any confirmed or suspected COVID-19 infection, and of any COVID-19 confirmed or suspected death.

Too many facilities failed to appropriately communicate with families about COVID-19 infections and deaths. Existing requirements that nursing homes communicate with family members within 24 hours of COVID-19 infections and deaths must be enforced. Nursing homes should utilize technology, including their websites, to communicate efficiently with families in compliance with confidentiality laws regarding the presence of COVID-19 infection within the facility, as well as on updates on scheduling visitation. Additionally, nursing homes must ensure that only trained staff engage in complex and compassionate communications with families.

Increase staffing at DOH to ensure sufficient skilled resources for oversight, complaint assessment, surveys, inspections and immediate responses to information requests from state agencies in support of health care and law enforcement efforts.

DOH faced an unprecedented challenge: an agency staffed to visit each nursing facility once per year, under stable conditions, was called upon to visit nearly every facility in barely two months, under emergency conditions. In addition, the preliminary investigations indicate that facilities often misreported basic information to DOH. The agency's enforcement and referral programs should be strengthened through additional staff.

Ensure that nursing homes engage in thoughtful planning regarding post-mortem care needs and implement and train staff on policies for dignified care of the remains of deceased residents.

Facilities should have clear policies that set forth protocols for the dignified treatment of remains. Staff should be effectively trained on the facility's policies and protocols for dignified treatment of remains while they are onsite, including emergency situations; and, ensure timely communication between management and staff as to the facility's active implementation of these measures, including informing staff of pre-designated alternative morgue locations.

Urge families to CMS Care Compare online database, ask questions of nursing homes relating to staffing, policies, procedures, and recent and current COVID-19 infections of staff and residents, and to obtain information relevant to their current or future long-term care decisions for their loved ones. Where possible, visit family member residents in person and through "window" visits and videocalls even if resident is unable to communicate, to provide emotional support and to enable observation of the resident's physical appearance and condition. Ensure family members know to report suspected neglect or abuse to DOH and OAG.

Before deciding on a nursing home, families should consult CMS ratings, and be armed with the appropriate questions to ask potential facilities. Additionally, nursing homes should facilitate communication with family members, either through window visits, video calls, or phone calls so that family members can provide emotional support to their loved one and observe the conditions in the facility.

Conclusion

This report provides an overview of OAG's preliminary investigative findings into the response by New York's nursing homes to the COVID-19 pandemic, and the heartbreaking reality that over 6,600 New Yorkers have died in nursing homes from complications related to COVID-19. OAG's investigations are ongoing. Attorney General James will continue to follow the facts, diligently and impartially, wherever they lead. In the meantime, given the ongoing COVID-19 pandemic and the risks to the state's estimated 90,000 nursing home residents as reflected by the data herein, systemic changes are warranted now. This report provides an overview of the recommended primary systemic reforms, as well as other measures that we believe will address the public's widely reported concerns about the pandemic's tragic impact on nursing home residents. As detailed in the report, nursing homes have a special obligation to the residents who depend upon the facility to meet every basic human need in what is for many, probably their last home. New York needs to ensure that nursing homes take care of our seniors and our most vulnerable residents with dignity, respect and the sufficient care that the law requires — and that the public primarily funds.

Attorney General Letitia James continues to encourage all residents, family members of residents and all caregivers to contact MFCU at (800) 771-7755 or at ag.ny.gov/nursinghomes if they believe that a patient in a residential health care facility has been neglected, abused, or mistreated.

Acknowledgments & MFCU Mission Statement

New York State's Medicaid Fraud Control Unit (MFCU) is a bureau within the Criminal Justice Division of the Office of the Attorney General of the State of New York. The Division of Criminal Justice is led by Chief Deputy Attorney General for Criminal Justice José Maldonado and overseen by First Deputy Jennifer Levy. MFCU's mission is to protect the public from all forms of fraud against the Medicaid program and to protect the state's vulnerable nursing home residents from exploitation, neglect, and abuse by unscrupulous providers. MFCU investigates and brings criminal prosecutions and civil actions to stop Medicaid provider fraud, to protect vulnerable residents, and to protect Medicaid program integrity.

This report is the collective product of investigative work undertaken since March 2020 by MFCU's 275 attorneys, forensic auditors, police investigators, medical analysts, data scientists, electronic investigation team, legal assistants, and support staff in eight offices across New York.

MFCU receives 75 percent of its funding from the U.S. Department of Health and Human Services under a grant award totaling $60,071,905 for Federal fiscal year (FY) 2019-20, of which $45,053,932 is federally funded. The remaining 25 percent of the approved grant, totaling $15,017,973 for FY 2019-20, is funded by New York state. Through MFCU's recoveries by means of law enforcement actions and civil enforcement actions, it regularly returns more to the state than it receives in state funding.

APPENDIX A (referenced on p. 9)

Table of Key Federal and State Guidance

Date	*Federal*	*New York*
1/21/20	CDC confirmed and announced the first case of COVID-19. cdc.gov/media/releases/2020/p0121-novel-coronavirus-travel-case.html	
1/31/20	HHS Secretary declared a public health emergency for the US, giving state, tribal, and local health departments flexibility to request HHS authorization to temporarily reassign personnel to respond to COVID-19. hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html	
2/6/20		DOH issued a letter to nursing homes and hospitals, asking "all facilities to compare their existing inventories of PPE, such as face shields, gowns, gloves, masks, N95 respirators, against the expected rate of use of these items under a surge situation, to determine the quantities needed to be on hand" and then to coordinate with existing vendors and local offices of emergency management to procure additional PPE. coronavirus.health.ny.gov/system/files/documents/2020/03/2020-02-06_ppe_shortage_dal.pdf
2/7/20	CDC's Morbidity and Mortality Weekly Report stated, "CDC is working closely with state and local health partners to develop and disseminate information to the public on general prevention of respiratory illness, including [COVID-19]. This includes everyday preventive actions such as washing your hands, covering your cough, and staying home when you are ill," and referred readers to CDC's website. It noted, "[t]hese measures are being implemented based on the assumption that there will be more U.S. [COVID-19] cases occurring with potential chains of transmission, with the understanding that these measures might not prevent the eventual establishment of ongoing, widespread transmission of the virus in the [U.S.]. It is important for public health agencies, health care providers, and the public to be aware of [COVID-19] so that coordinated, timely, and effective actions can help prevent additional cases or poor health outcomes."[107] cdc.gov/mmwr/volumes/69/wr/mm6905e1.htm	

3/4/20	**CMS published to State Survey Agencies a Guidance for Infection Control and Prevention of COVID-19 in Nursing Homes**, with information on (1) screening and, if necessary, restricting visitors to nursing homes; (2) screening and, if necessary, restricting employees with signs or symptoms of COVID-19 from working in the facility; (3) when to transfer residents to the hospital; and, (4) when a nursing home should accept a resident diagnosed with COVID-19 from the hospital. It stated that "a nursing home can accept a patient with a COVID-19 diagnosis who is still under Transmission-Based Precautions "as long as it can follow CDC guidance for [T-BP]. If a nursing home cannot, it must wait until precautions are discontinued." (See Transmission-Based Precautions Guidance from CDC.) The CMS guidance stated that nursing homes should admit any individuals that they would normally admit, including from hospitals where a case of COVID-19 was present. cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf	
3/4/20	CMS published guidance to State Survey Agency Directors on, among other things, discharging patients with COVID-19 diagnoses to subsequent care facilities. CMS instructed that the decision to discharge a patient transfer should be based on clinical considerations of the patient, and that if T-BP must be continued, the receiving facility must be able to implement all recommended infection prevention and control recommendations. Medicare hospital planning required all medically necessary information, including communicable diseases, be provided to post-acute care providers for COVID-19, prior to discharge. cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2	

3/7/20	CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel (HCP) with Potential Exposure in a Healthcare Setting." The guidance states that "contact tracing, monitoring, and work restrictions. . . includ[ing] allowances for asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program." It stated that asymptomatic staff exposed to COVID-19 were "not restricted from work." fluxguard.com/coronavirus/site/331dd37e-f2af-4323-9424-0e0cc4dee8aa/session/9cf5a974-73a6-4fcf-a397-9d68cf59342d/page/a0400044-4df1-47b2-ae8d-f318b3c27c5c/txtview?actionId=6564a241-1186-4b51-8185-9cc4da76263f&captureId=1583805385934	Governor Cuomo declared a Disaster Emergency due to COVID-19, state that a "disaster is impending in New York State, for which the affected local governments are unable to respond adequately." Executive Order 202 governor.ny.gov/news/no-202-declaring-disaster-emergency-state-new-york

3/11/20		DOH issued guidance to nursing home owners/ operators and administrators regarding "precautions and procedures nursing homes must take to protect and maintain the health and safety of their residents and staff during" the COVID-19 outbreak. The guidance noted that it was essential that all nursing home owner/ operators, administrators, and clinical staff maintain situational awareness about the disease, its signs and symptoms, and necessary infection prevention and control procedures and review the most up-to-date information for health care providers. The guidance still permitted visitation but required screening of visitors and recommended modified hours. It also required employee screening and that staff showing symptoms "not be permitted to remain at work" and "not return to work until completely recovered." It required 14-day voluntary or mandatory quarantine for an asymptomatic staff person who had potential exposure to COVID-19 following the exposure. It required a mandatory 14-day quarantine for symptomatic staff following the date of onset of symptoms. It provided information on conserving PPE, but specifically instructed that facilities' controls should not discourage the use of masks when indicated for patient care. It emphasized the need to reinforce infection control regulations at 10 NYCRR § 415.19 and noted that residents suspected of infection with COVID-19 should be given a surgical or procedure mask (not an N95) and that while awaiting the transfer, the resident must be isolated in a separate room with the door closed. DOH also (1) restricted visitation in nursing homes; (2) provided information on conserving PPE but specifically instructed that facilities' controls should not discourage the use of masks when indicated for patient care; and, (3) set forth practices to prevent the spread of COVID-19. It described the symptoms of COVID-19 and conveyed the obligation and need to often check for updates on CDC, and DOH Health Commerce System websites for situational awareness, symptoms, and infection control. It emphasized the need to reinforce infection control regulations 10 NYCRR § 415.19 and noted that residents suspected of infection with COVID-19 should be given a surgical or procedure mask (not an N95) and that while awaiting the transfer, the resident must be isolated in a separate room with the door closed. coronavirus.health.ny.gov/system/files/ documents/2020/03/nursing_home_guidance.pdf

3/13/20		**DOH issued updated COVID-19 Health Advisory Guidance** to nursing homes and adult care facilities suspending all visitation, except where it was medically necessary or for imminent end-of-life situations.[108] The advisory also required facilities to immediately implement health checks for all HCP before each shift and require that all HCP wear a facemask while within six feet of residents. If there were confirmed cases of COVID-19, the advisory required nursing homes and adult care facilities to (1) notify the local health department and DOH if not already involved; (2) monitor all residents on affected shifts; (3) assure that all residents in affected units remained in their rooms to the extent possible; (4) require residents to wear facemasks when HCP entered their rooms, unless resident could not tolerate facemasks; (5) preclude "floating" staff between units, minimize staff entering rooms, and cohort positive residents with dedicated providers; (6) place residents on affected units on "droplet and contact precautions"; and, (7) required re-testing immediately residents who initially tested negative, if they developed symptoms consistent with COVID-19. If there were suspected cases of COVID-19, residents were to be given a facemask and isolated in a separate room with the door closed. The advisory required that staff should wear full PPE and maintain social distancing of at least six feet from resident except for "brief, necessary interaction." coronavirus.health.ny.gov/system/files/documents/2020/03/acfguidance.pdf

3/16/20	CDC issued updated guidance on time tables for HCP with confirmed or suspected COVID-19 to return to work, instructing officials to use one of two strategies. Under the "test-based strategy," CDC advised that HCP should be excluded from work until (1) resolution of fever without the use of medication; (2) improvement in respiratory symptoms; and, (3) after at least two negative test results taken at least 24 hours apart. Under the "non-test-based strategy," CDC advised that symptomatic HCP should be excluded from work until (1) "at least 3 days (72 hours) have passed since recovery (defined as resolution of fever without the use of medication), (2) "improvement of respiratory symptoms," and (3) "at least 7 days have passed since symptoms first appeared." It acknowledged that appropriate state and local authorities "might determine that the recommended approaches cannot be followed due to the need to mitigate HCP staffing shortages." phdmc.org/program-documents/healthy-lifestyles/gumc/emergency/covid-19/physicians-healthcare-providers/1449-return-to-work-criteria-for-healthcare-workers/file	DOH issued updated guidance advising that "facilities may allow HCP exposed to or recovering from [COVID-19]" to work if: • Furloughing such staff would result in shortages that adversely impact the operation of the facility; • HCP who had contact with confirmed or suspected cases are asymptomatic; • Symptomatic HCP with confirmed or suspected COVID-19 isolated for at least 7 days after illness onset and were fever-free at least 72 hours with other symptoms improving. • HCP who were asymptomatic after contact with confirmed or suspected cases were directed to self-monitor twice a day (temperature, symptoms), and undergo temperature monitoring and symptom checks at the beginning of each shift and at least every 12 hours. • Staff who recovered from COVID-19 were directed to wear a facemask until 14 days after onset of illness if mild symptoms persisted but were improving. • Staff who were asymptomatic after contact were directed to wear a facemask while working until 14 days after the last high-risk exposure. Staff working under these conditions were to be assigned to patients at lower risk (on COVID-19 units) as opposed to severely immunocompromised or elderly patients. If staff developed symptoms, they were directed to immediately stop work and isolate at home. Testing was prioritized for hospitalized health care workers. All staff with symptoms consistent with COVID-19 were assume they were COVID-19 positive regardless of the availability of test results. nyshfa-nyscal.org/files/2020/03/Advisory-HCP-return-to-work-20200316-final.pdf

3/18/20		Executive Order 202.5 allowed transfer to Article 28 facilities and suspended regulations: • 10 NYCRR § 400.12 to the extent necessary to allow patients affected by the disaster emergency to be transferred to receiving Article 28 facilities; • 10 NYCRR § 415.15 to the extent necessary to permit facilities receiving individuals affected by the disaster emergency to obtain physician approvals for admission as soon as practicable or to forego such approval for returning residents; and, • 10 NYCRR § 415.26 to the extent necessary to permit facilities receiving individuals affected by the disaster emergency to comply with admission procedures as soon as practicable after admission or to forego such approval for returning residents. governor.ny.gov/news/no-2025-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
3/21/20		DOH issued guidance with different testing protocols for facilities within New York City, Long Island, Westchester, and Rockland Counties – which had "sustained community transmission" of COVID-19 – and for facilities located in the rest of the state. It stated that in the nine downstate counties, "testing of residents and [HCPs] with suspect COVID-19 is no longer necessary and should not delay additional infection control actions" for any resident with symptoms of a febrile respiratory illness, and that such residents should be presumed to be COVID-19 positive. Facilities outside of these nine counties "should continue to pursue testing for residents and health care workers with suspect COVID-19 to inform control strategies." coronavirus.health. ny.gov/system/files/documents/2020/03/22-doh_covid19_nh_alf_ilitest_032120.pdf
3/23/20	CDC published Transmission-Based Precautions (T-BP) and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance) stating that "a patient can be discharged from the healthcare facility whenever clinically indicated: If discharged to a long-term care or assisted living facility," and T-BP were still required, the patients "should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with COVID-19." The guidance indicated that preferably, the patient would be placed in a location "designated to care for COVID-19 residents." If T-BP had been discontinued, the patient does not require further restrictions, based upon their history of COVID-19 infection. hsdl.org/?view&did=836726	Executive Order 202.10 included specified immunity for health care providers, including from civil liability for any injury or death alleged to have been sustained directly as a result of an act or omission by such medical professional in the course of providing medical services in support of the state's response to the COVID-19 outbreak, unless it is established that such injury or death was caused by the gross negligence of such medical professional. The executive order relieved health care providers of certain record keeping requirements to the extent necessary for them to perform tasks as necessary to respond to the COVID-19 outbreak and provided them immunity from liability for failure to comply with recordkeeping requirements if they acted reasonably and in good faith. governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency

3/25/20		DOH issued guidance to nursing home administrators, directors of nursing and hospital discharge planners stating, "No resident shall be denied re-admission or admission to the nursing home 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 re-admission." It also provided information on how to request PPE from DOH. (On May 26, DOH removed this guidance from its website.) skillednursingnews.com/wp-content/uploads/sites/4/2020/03/DOH_COVID19__NHAdmissionsReadmissions__032520_1585166684475_0.pdf
3/31/20		DOH issued guidance on April 1, dated March 31, entitled "Protocols for Essential Personnel to Return to Work Following COVID-19 Exposure or Infection." coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19_essentialpersonnelreturntowork_rev2_033120.pdf
4/3/20	HHS-Office of Inspector General issued "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020," OEI-06-20-00300, noting CDC delay in producing COVID-19 test, and hospital reports of need for PPE, testing, staffing, supplies and equipment, delays waiting for test results and challenges maintaining or expanding their facilities' capacity to treat patients with COVID-19.[109] oig.hhs.gov/oei/reports/oei-06-20-00300.asp	
4/6/20		The Emergency Disaster Treatment Protection Act was enacted to "promote the public health, safety and welfare of all citizens by broadly protecting the health care facilities and health care professionals in this state from liability that may result from treatment of individuals with COVID-19 under conditions resulting from circumstances associated with the public health emergency." PHL § 3080. (See Section VI(G) above for the statute's text.) nysenate.gov/legislation/laws/PBH/A30-D

4/13/20	CDC issued updated guidance entitled "Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19" to express a preference for the test-based strategy for HCP to return to work, if feasible, yet still accepted the non-test based model. According to the guidance, asymptomatic staff who tested positive COVID-19 "should be excluded from work until 10 days after the date of their first positive COVID-19 diagnostic test" if they have remained asymptomatic throughout that time. web.archive.org/web/20200417191400/https:/www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html	
4/16/20		Executive Order 202.18 required nursing homes to notify family members within 24 hours of a resident COVID-19 diagnosis or death. governor.ny.gov/news/no-20218-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
4/17/20		Executive Order 202.19 directed DOH to establish "a single, statewide coordinated testing prioritization process" that required all laboratories in the state, both public and private, to coordinate with the DOH and prioritize COVID-19 testing. governor.ny.gov/news/no-20219-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
4/29/20		DOH issued a letter to nursing home administrators stating that the state would no longer adhere to CDC's "shorter" standard on HCP returning to work as set forth in CDC's interim guidance. DOH required that a nursing home HCP who tested positive for COVID-19 but remains "asymptomatic" not return to work "for 14 days from [the] first positive test date in any situation." It stated, "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." It invited "nursing homes facing staffing difficulties" to use DOH's online staffing portal, noting 200 facilities used it as of April 29. coronavirus.health.ny.gov/system/files/documents/2020/05/nh-letterregardingemployees-4.29.20.pdf

5/10/20		Executive Order 202.30 required nursing homes to make arrangements for COVID-19 testing of all personnel twice per week and report any positive test to DOH the next day. It also required the operator and the administrator of each home to provide to DOH a certification of compliance with the Executive Order and "directives of the Commissioner of Health." governor.ny.gov/news/no-20230-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
6/10/20		Executive Order 202.40 continued the directives of EO 202.30 yet modified them to require nursing homes to make arrangements for COVID-19 testing of all employees, contract staff, medical staff, operators and administrators once per week for all nursing homes and all adult care facilities that are located in regions that have reached Phase Two of New York state's reopening plan.
6/17/20		Public Health Law § 2803(12) requires residential health facilities to submit to DOH an annual "Pandemic Emergency Plan" by 9/15/20. nysenate.gov/legislation/laws/PBH/2803#:~:text=(a)%20The%20commissioner%20shall%20have,including%20health%2Drelated%20service%2C%20system

APPENDIX B

An Illustration of the Too Prevalent "Low Staffing for Profit" Model of Exploitation Through Insufficient Staffing, Lack of Transparency, and Financial Incentives: a Pre-Pandemic OAG Investigation, Findings, and Prosecution

The 2018 investigation described below is relevant to the COVID-19 pandemic because the operating model for staffing that led to systemic abuse and neglect at this facility remains prevalent in too much of the for-profit sector of the nursing home industry in New York. Of the state's 619 total nursing homes, 401, or 61 percent, are for-profit entities. The chronic staffing failures caused neglect throughout the facility even without a severe external strain such as COVID-19.

Most nursing homes operate on a model that essentially seeks 100 percent resident capacity at the facility every day, because billing and insurance payments are per-day, per-patient. Each empty bed is lost potential revenue. Conversely, from too many facilities' perspectives, each additional resident does not require additional staffing if the time and labor of the staff already on-duty can be stretched and shifted to assign coverage for the care needs of the patients. Every facility has some financial incentive to avoid hiring additional staff, because each staffer's pay, and benefits (if any), are an expense. However, if a nursing home stretches that staffing model to assign employees to cover the care needs for too many residents – with insufficient numbers of appropriate employees – the model snaps.

1. OAG Pre-Pandemic Investigation of Focus at Otsego Nursing Home

OAG conducted an investigation of allegations of neglect of residents in Focus Rehabilitation and Nursing Center at Otsego (Focus), a 174-bed nursing home in Cooperstown, New York, after a number of earlier incidents that resulted in arrests of several health care workers for offenses including neglect of residents and falsification of medical records to conceal neglect. In one incident of neglect, a 94-year old resident was left in a recliner in a common living room area of the facility for approximately 41 hours during a holiday weekend without appropriate care, treatment, or service. The investigation included an inquiry into systemic causes of neglect of Focus residents. To obtain the facts that resulted in the investigative findings, OAG conducted extensive forensic accounting investigation and detailed analysis of medical and staffing records relating to the Focus nursing home. This work was required to bring transparency to what happened to millions of Medicaid reimbursement dollars that went through many financial transactions from the facility to related parties. (See Appendix B at B-1, Funding Flow Through chart). It also included significant investigation and analysis of records of staffing levels.

2. Findings: Chronic Insufficient Staffing Increased Resident Neglect and Harm; Lack of Transparency in Profit-taking

The findings of this investigation included that the owners and management of Focus cut staffing at the facility in late 2014 in order to increase their personal profit, through a variety of financial transactions with related parties.[110] The cuts in staffing at Focus resulted in:

- » Neglect and injury to residents of the facility;
- » Increased risk of injury to residents of the facility;
- » Very challenging working conditions for the direct care staff whose responsibilities included providing care for the residents in accordance with their plans of care;
- » Resignations of direct care staff members in frustration after unsuccessful warnings to owners and management that the insufficient staffing levels created risks for the residents and untenable working conditions;
- » Refusals by the operator, 99 percent owner, and manager to increase the facilities' budget and reverse insufficient staffing levels at Focus;
- » Use of staff from a "temporary agency staffing" company owned by a party to the defendant manager, in lieu of hiring full time staff; and,
- » Failure to maintain staff even at the level deemed "critical" by other licensed managers.

Routine reliance on temporary agency staff in lieu of full-time employees to fill budgeted staffing levels resulted in staffing that met fewer residents' care needs. Agency staff, who are sent to any nearby facility to work any shift on any assignment within the facility, are usually less familiar with each of the resident's care needs, facility protocols, facility resources, medical professional resources, and therefore, less effective in delivering care. Agency staff must often familiarize themselves with each resident's chart and care plan in order to provide appropriate care. Agency staff also often have less familiarity with facility policies, operations, and personnel, which can result in the need for more time to complete work.[111]

3. Prosecution, Convictions, and Civil Remedies

Prosecution: Based on relevant aspects of these findings, in May 2018, OAG filed criminal charges against the entity that held the operator's license for, and controlled, Focus, an individual who was the 99 percent owner of Focus, and an individual who was the owner's business partner in other ventures while acting as a high level manager for Focus, for their conduct between October 14, 2014 to December 31, 2017. The charges included three felony counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, in violation of Penal Law § 260.25, a Class E felony: one count as to all residents of the facility from October 14, 2014 to November 29, 2016, and two counts as to two specific residents who each suffered injury. The charges against each defendant also included two misdemeanor counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the Second Degree in violation of Penal Law § 260.24 ("Misdemeanor Endangering") as: one count as to all residents of the home from May 26, 2016 to November 29, 2016, and one count as to a specific resident from May 28, 2016 to June 1, 2016; and, two misdemeanor counts of Willful Violation of Health Laws, in violation of Public Health Law §§ 12-b(2), 2803-d(7), and 10 NYCRR §§ 81.1, 415.11 and 415.12(c)(2): one count for the neglect of all the residents of the home from May 26, 2016 to November 29, 2016, and one count for the neglect of a specific resident from May 28 to 30, 2016.

Convictions and Assurance of Discontinuance: In September 2018, the corporate operator's 99 percent owner and its manager both pleaded guilty to misdemeanor Endangering, and also entered a civil Assurance of Discontinuance under Executive Law § 63(15) in which they agreed to repay $1 million to the New York State Medicaid program, and to be voluntarily excluded from Medicaid and from operating health care businesses in New York state for 5 years. The corporate operator pleaded guilty to felony Endangering and was dissolved. Absent OAG's investigation, findings, prosecution, and civil remedy of an Assurance of Discontinuance, it is most likely that the owner, manager, and Focus corporate operator would have been operating the Focus nursing home during the COVID-19 pandemic with levels of staffing that were insufficient to meet the pre-pandemic needs of the residents for care and services. Fortunately, this result and its predictable negative outcomes were prevented.

4. Law Enforcement Resource Investment

Conducting the investigation regarding the Focus nursing home noted above, and reflected in part in Appendix B-1, required a significant amount of OAG resources and expertise. Many law enforcement agencies lack the resources to conduct such comprehensive investigations of the financial transactions and records that identify and address what can be a root cause of incidents of neglect – i.e., insufficient staffing.[112] A more efficient way to address the problem of chronic insufficient levels of staffing in for-profit nursing homes is to require effective minimum staffing levels and transparency in financial relationships with all related parties.
(See Recommendations D and E in Section VIII)

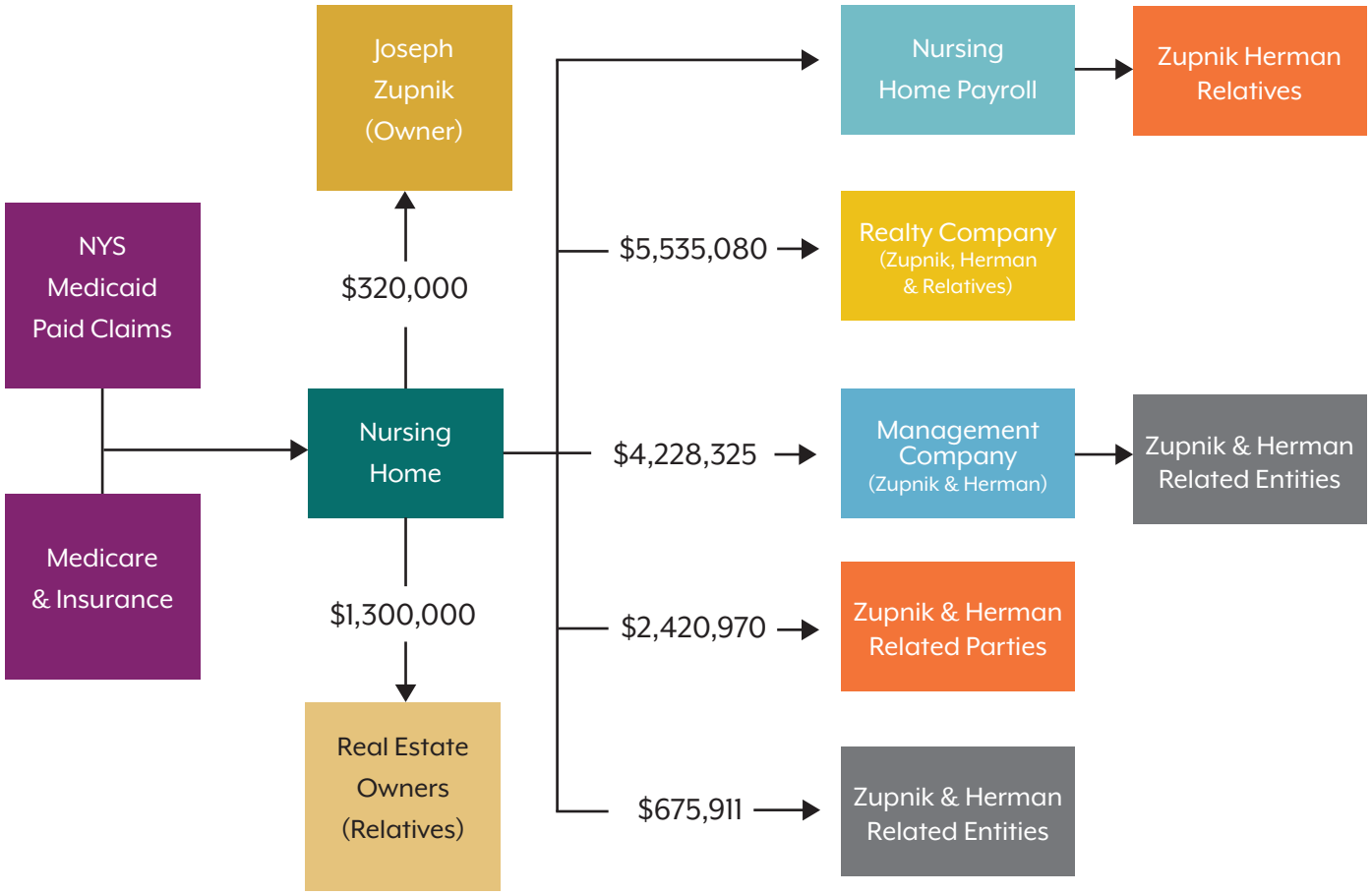
5. Similar Findings Regarding Lack of Transparency in Operation of Some For-Profit Nursing Homes

News organizations and advocacy groups have published findings about the ways in which too many for-profit nursing homes operate – specifically by extracting money from the facility and transferring it to investors, owners and related parties through divided ownership interests, mortgages, leases,[113] contracts and arrangements for services, such as management services, agency staffing, rehabilitation services, laundry and food services. Against the backdrop of lack of transparency regarding the related party financial transactions, members of the for-profit nursing home industry have claimed government reimbursement rates are "too low." As shown in the chart attached hereto as Appendix B-1, self-dealing obscures the true net revenue of such operations. Such transactions create a balance sheet that may suggest the facility is running even or at a loss, when in fact the owners are taking out profits as "fees", salaries for low-activity positions, or revenue to affiliated businesses.[114] The question whether reimbursement rates should be increased to enable for-profit nursing homes to provide care they are obligated to provide cannot be answered without full transparency into the facilities' mortgages, leases, management and "consulting" companies, contracts and arrangements for services.

Appendix B-1

Related Party Transactions at a Nursing Home

October 2014 - December 2017 Funds Directly Paid to Related Parties



Appendix B-2

The Nursing Care Center [redacted]
Sunday April 12, 2020

Census: 289	0Facility	1B	1C
7a-7p		[redacted]	[redacted]
3p-11p (60 min)	[redacted]	[redacted]	[redacted]
3p-11p (45 min)	[redacted]	[redacted]	[redacted]
7p-7a		[redacted]	Nurse [redacted]

Notes

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The Nursing Care Center [redacted]
Sunday April 12, 2020

Census: 289	2A	2B	2C
7a-7p			
3p-11p (60 min)	Nurse [redacted]	Nurse [redacted]	Nurse [redacted]
3p-11p (45 min)	[redacted]	[redacted]	[redacted]
7p-7a	[redacted]	[redacted]	[redacted]

Notes

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DATE: Friday, [?]uary 13,2017 [redacted] Rehabilitation and Nursing C[?]ter Daily Nursing Staff Sheet

[?]AYS		EVENINGS		NIGHTS	
RN SUP/ [redacted]		RN SUPERVISOR: [redacted]		RN SUPERVISOR: [redacted]	
UNIT 2		UNIT 2		UNIT 2	
NURSES	C.N.A.	NURSES	C.N.A.	NURSES	C.N.A.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
UNIT 3		UNIT 3		UNIT 3	
RN SUPERVISOR:	[redacted]				
NURSES	C.N.A.	NURSES	C.N.A.	NURSES	C.N.A.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

Endnotes

[1]The investigation was conducted by the Medicaid Fraud Unit (MFCU), a federally funded, multi-disciplinary unit within the OAG that serves a dual mission to investigate Medicaid provider fraud and the abuse and neglect of patients in residential health care facilities, and bring civil and/or criminal remedies to address wrongdoing.

[2]All dates are in the year 2020 unless otherwise specified.

[3]This was following an Executive Order issued by Governor Andrew Cuomo relating to communications between nursing homes and family members.

[4]On September 3, CMS launched Care Compare, a redesign of eight existing CMS health care compare tools that were available on Medicare.gov, including Nursing Home Compare, which previously contained CMS's ratings for each nursing home in the four categories of Overall, Staffing, Infection Control and Quality of Care. medicare.gov/care-compare

[5]The legislature enacted, and the governor signed, amendments to Public Health Law §§ 3081-82 effective August 3, limiting the scope of immunity to acts relating to the "diagnosis or treatment of COVID-19" or "the assessment or care of an individual as it relates to COVID-19, when such individual has a confirmed or suspected case of COVID-19," and eliminating a clause concerning care of any other individuals. However, the potential defenses as to resources or staffing shortages were not amended.

[6]hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html

[7]CDC issued guidance for uniform reporting of COVID-19 vital health statistics: deaths of people whose laboratory tests resulted in a COVID-19 positive diagnosis and where COVID-19 played a role in the death should be reported as "confirmed" COVID-19 deaths. The guidance also provides that where a definite COVID-19 diagnosis cannot be made but is suspected or likely given the circumstances, a COVID-19 death may be reported as "presumed." cdc.gov/nchs/data/nvss/vsrg/vsrg03-508.pdf

[8]health.ny.gov/statistics/diseases/covid-19/fatalities_nursing_home_acf.pdf

[9]"New York Coronavirus Map and Case Count," *The New York Times*, nytimes.com/interactive/2020/us/new-york-coronavirus-cases.html

[10]Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, and Westchester counties.

[11]As of August 3, nursing home deaths due to COVID-19 were reported in 40 counties: Albany, Bronx, Broome, Chenango, Columbia, Dutchess, Erie, Fulton, Greene, Herkimer, Kings, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Richmond, Rockland, Schenectady, Steuben, Suffolk, Sullivan, Tioga, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, and Yates.

[12]The data has not yet been verified against other data sources.

[13]The DOH data used for 58 of the 62 facilities was the data published on the date that matched the end of the timeframe of the data reported by each facility to OAG, or if DOH had not published data on that day, the data published on the following date. For four facilities reporting data to OAG for a timeframe ending prior to May 3, the DOH data published as of that date was used. This is because the data DOH published before May 3 for those facilities reflected no or few deaths, whereas the data DOH published as of May 3 reflected an increase in deaths at those facilities and was expressly stated as including presumed and confirmed COVID19 deaths.

[14]Through July 16, DOH reported one confirmed death at the facility, and as of July 30, DOH reported 11 confirmed deaths at the facility.

[15]At the same time, to the extent that the discrepancy results from the omission in DOH published data of resident deaths that occurred in hospitals, the under-counting of nursing home resident COVID-19 deaths does not reflect under-counting of total NYS COVID-19 deaths.

[16]The New York State Cemetery Board issued emergency crematory regulations adopted by the New York State Cemetery Board on May 1, 2020 that permitted funeral homes to transfer deceased awaiting cremation to crematories with ready capacity. With this change, for which Attorney General James advocated and her designee to the Cemetery Board voted, funeral directors, with the consent of the family of the deceased, have been able avoid significant delays by manually correcting cremation authorization forms rather than needing to create a new form and obtain another physical signature from the person arranging the funeral.

[17]Meaghan. McGoldrick, "Staffers say that bodies at Brooklyn nursing home are 'piling up'," *amny*, April 14, 2020

[18]"Coronavirus Deaths: Officials Told 'Bodies Being Piled Up In Nursing Homes' As Desperate Families Face Silence," CBS New York, April 14, 2020

[19]OAG's hotline reflected instances where residents' families were contacted by, or were only able to contact, nursing home employees unprepared to deliver such news, without the training, knowledge, and expertise to provide the appropriate end of life communications usually performed by experienced licensed nurses and social workers. In others, upon making inquiry as to their loved ones' mortal health risks, families were told that authorized persons were unreachable due to personal religious observances or days off and that their call would have to wait.

[20] The analysis focuses on the data through August 3, because this was the period of the first wave, when infection and death rates were concentrated downstate.

[21] 10 NYCRR § 415.19.

[22] Failure to have robust infection prevention and control policies could constitute resident neglect for failing "to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or resident of a residential health care facility." 10 NYCRR § 81.1(c). "Willful" neglect is a misdemeanor punishable by imprisonment not exceeding one year, a $10,000 fine or both. Public Health Law § 12-b(2).

[23] DAL NH 20-04 COVID-19 Guidance for Nursing Homes – Revised, Mar 11, 2020, coronavirus.health.ny.gov/system/files/documents/2020/03/nursing_home_guidance.pdf

[24] Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCOV), Feb 6, 2020. cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/information-healthcare-facilities-concerning-2019-novel-coronavirus-illness-2019-ncov

[25] Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings, Mar 13, 2020, cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf

[26] New York nursing homes are required to have a written "disaster and emergency preparedness" plan, updated at least twice a year, with procedures to be followed for the proper care of residents and personnel in the event of "an internal or external emergency resulting from natural or man-made causes." 10 NYCRR § 415.26(f).

[27] Aspiration precautions are taken for residents at high risk of choking during self-feeding, with a staff member staying nearby to watch.

[28] health.ny.gov/facilities/nursing/about_nursing_home_reports.htm#comdefrr

[29] DOH spearheaded 1,300 onsite infection control inspections, including of every nursing home and adult care facility, and initiated its own administrative enforcement actions against a number of nursing homes for violations of infection control protocols, of HERDS data reporting requirements, and of Executive Order 202.18 communication requirements.

[30] OAG continues to receive complaints of neglect of residents that occurred during the pandemic in New York.

[31] Some staff reassignment was permissible under emergency COVID "scope of practice waivers" issued by DOH, such as shifting clerical or food service staffers to work as CNAs. Those emergency waivers were to offset the already-critical staffing crisis, not new employment opportunities.

[32]*Nursing Home and ACF COVID Related Deaths Statewide* (web-published daily by NYS DOH), accessed daily, using data published through 11/16/20. The published data notes, "This data captures COVID-19 confirmed and COVID-19 presumed deaths within nursing homes and adult care facilities. This data does not reflect COVID-19 confirmed or COVID-19 presumed positive deaths that occurred outside of the facility. Retrospective data reporting dates back to March 1, 2020."

[33]This analysis utilized the CMS quarterly metrics from June. Although CMS waived certain reporting requirements in 2020 at various times and held certain data points constant, there is no reason to believe that staffing and outcomes improved during the waiver periods. CMS has stated that it will resume calculating nursing homes Health Inspection and Quality Measure ratings on January 27, 2021.

[34]As noted in DOH Revised Report (7/20/20) and consistent with OAG analysis, this drop is despite the location of most CMS 5-Star Overall rated facilities in the hardest-hit counties.

[35]OAG continues to explore the anomalous rate shown by CMS 5-Star Staffing and 2-Star Overall rated facilities. There are few facilities in this group, and perhaps other poor practices result in little net difference from the COVID-19 death rate for a CMS 1-Star Staffing and 1-Star Overall rating combination. (There are no data points for CMS 1-Star Staffing and 4- or 5-Star Overall rated facilities, as the CMS methodology does not permit those combinations.)

[36]medicare.gov/nursinghomecompare/search.html

[37]skillednursingnews.com/2018/11/new-york-officials-call-greater-scrutiny-non-profit-nursing-home-sales

[38]DOH Revised Report 7/20/20 at pp. 23-24.

[39]OAG also accounted for a sample that ensured that at least one facility at each star level was in the county.

[40]The New York State Office of Emergency Management (OEM) is an office within the division of the NYS Division of Homeland Security and Emergency Services (DHSES).

[41]Executive Order 202.40, issued June 10, 20, continued this testing requirement yet modified it to a once a week testing requirement for nursing homes in areas in the second phase of the State's multi-tiered reopening plan.

[42]This approach of placing to onus on staff to obtain testing is less likely to result in staff being tested because many staff Statewide have low salaries and lack health insurance.

[43]DOH, Advisory: Hospital Discharges and Admissions to Nursing Homes, March 25, 2020

[44]DOH Revised Report at pp. 4-5.

[45]While some commentators have suggested DOH's March 25 guidance was a directive that nursing homes accept COVID-19 patients even if they could not care appropriately for them, such an interpretation would violate statutes and regulations that place obligations on nursing homes to care for residents. For example, New York law requires a nursing home to "accept and retain only those residents for whom it can provide adequate care." See 10 NYCRR § 415.26(i)(1)(ii). Preliminary findings show a number of nursing homes implemented the March 25 guidance with understanding of this fundamental assessment.

[46]U.S. Dep't of Health and Human Services Office of the Inspector General, "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020," OEI-06-20-00300 dated April 2020. The HHS-OIG report's key findings included hospitals reporting that "their most significant challenges centered on testing and caring for patients with known or suspected COVID-19 and keeping staff safe." Hospitals also reported challenges maintaining or expanding their facilities' capacity to treat patients with COVID-19, and frequently waiting seven days or longer for COVID-19 test results. Hospitals reported that as "patient stays were extended while awaiting test results, this strained bed availability, [PPE], supplies, and staffing." In addition, "acute care capacity concerns emerged as hospitals anticipated being overwhelmed if they experienced a surge of patients" who may require special beds and rooms to treat and contain infections.

[478]ibid.

[48]ibid.

[49]*See* DOH Revised Report at 25.

[50]*See* DOH Revised Report at 19-20.

[51]*See* DOH published nursing home death data as of August 8. *An earlier version of this report suggested a number of facilities that had potentially not been exposed to COVID-19 prior to the March 25th guidance. That number has been removed, but the overall findings remain unchanged.

[52]PHL § 3080

[53]Though amendments were enacted to Public Health Law §§ 3081-82 effective August 3, limiting the scope of immunity to acts relating to the "diagnosis or treatment of COVID-19" or "the assessment or care of an individual as it relates to COVID-19, when such individual has a confirmed or suspected case of COVID-19," and eliminating a clause concerning care of any other individuals, the potential defenses as to resources or staffing shortages were not amended.

[54]Public Health Law § 3082.

[55]ibid.

[56]Very few nursing home residents are completely "self-pay," without some form of private or public insurance.

[57]Notably, OAG investigations have revealed different structures and power balances between licensed administrators and owners in other for-profit facilities, compared to the above example. NYS Nursing Home regulations do not mention "owners" as part of the admissions process. 10 NYCRR § 415.26(i).

[58]10 NYCRR § 415.1(1)(a)(1).

[59]10 NYCRR § 415.1(1)(a)(5)

[60]10 NYCRR § 415.12

[61]10 NYCRR § 415.26(i)(1)(ii)

[62]10 NYCRR § 415.13

[63]10 NYCRR § 415.11(c)

[64]10 NYCRR § 415.3(a)

[65]10 NYCRR § 415.2(f)

[66]42 C.F.R. § 483.1.

[67]42 C.F.R. § 483.24

[68]42 C.F.R. § 483.25 ("Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices…").

[69]42 C.F.R. § 483.10; *See also* 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[70]42 C.F.R. § 483.10; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[71]42 C.F.R. § 483.12.

[72]42 C.F.R. § 483.25.

[73]42 C.F.R. § 483.20; 42 C.F.R. § 483.21; *See also* 42 C.F.R. § 483.21; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[74]42 C.F.R. § 483.21; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[75]42 C.F.R. § 483.24.

[76]ibid.

[77]ibid.

[78]42 C.F.R. § 483.30; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[79]42 C.F.R. § 483.35; *See also,* 42 U.S.C. § 1395i-3.

[80]42 C.F.R. § 483.60; *See also,* 42 U.S.C. § 1395i-3.

[81]42 C.F.R. § 483.50; 42 C.F.R. § 483.55; *See also* 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[82]42 C.F.R. § 483.40; *See also,* 42 U.S.C. § 1395i-3.

[83]42 C.F.R. § 483.70; *See also,* 42 U.S.C. § 1395i-3.

[84]ibid.

[85]ibid.

[86]42 C.F.R. § 483.75; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[87]42 C.F.R. § 483.85.

[88]42 C.F.R. § 483.70(e).

[89]42 C.F.R. § 483.73. *See also* 10 NYCRR § 415.26(f).

[90]ibid.

[91]42 C.F.R. § 483.80; *See also* 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[92]42 C.F.R. § 483.80.

[93]ibid.

[94]Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program, 85 FR 27550-01. The additional requirements include the reporting of COVID-19 information, including deaths, suspected and confirmed infections, PPE supply, ventilator supply; access to testing; and staffing shortages to CDC on at least a weekly basis. The changes also include a requirement for facilities to inform residents and their families each time there has been a confirmed infection of COVID-19, or when three or more residents or staff display newly-onset respiratory symptoms within 72 hours of each other. They must inform residents and their families and representatives of such occurrence by 5pm the next calendar day and must provide cumulative updates at least weekly. 42 C.F.R. § 483.80(g).

[95]42 C.F.R. § 483.70(n).

[96]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34737.

[97]ibid.

[98]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34747, 34746.

[99]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34738, 34745.

[100]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34748, 34745-6.

[101]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34745.

[102]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34749-50. These survey reports are the product of required state surveys of facilities that seek to assess compliance with statutes and regulations that facilities have notice of and are required to follow. Permitting facilities to wait to upload the data onto the CASPER system until a pending dispute resolution process has concluded would deprive residents and consumers of vital information that is accurate and relevant to their healthcare decisions, including which facility to reside in, or entrust a loved one to.

[103]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34740.

[104]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34737, 34740-41.

[105]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34738, 34743-4.

[106]*See* Sections VI(A), (B), and (G), and Appendix B, B-1, and B-2.

[107]Patel A, Jernigan DB. Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak — United States, December 31, 2019–February 4, 2020. MMWR Morb Mortal Wkly Rep 2020;69:140–146. DOI: cdc.gov/mmwr/volumes/69/wr/mm6905e1.htm

[108]DOH issued new guidance effective September 17, 2020 that permitted nursing homes that have been without COVID-19 infection for at least 14 days to resume limited visitation under restrictions designed to keep residents safe from infections of COVID-19. This was a revision to the 28-day guidelines previously set by CMS, which also issued guidance regarding the 14-day period following any COVID-19 infection in the facility.

[109]The HHS-OIG report was issued on April 3 by Principal Deputy Inspector General of HHS OIG Christi A. Grimm, who was also serving as Acting Inspector General of HHS-OIG at the time. The President reportedly sought to remove Grimm from the latter position after he expressed displeasure on April 6 at the report's findings. On May 26, Acting Inspector General Grimm testified before Congress, emphasizing "the importance of independent oversight from the nation's watchdogs." pbs.org/newshour/politics/watch-live-hhs-watchdog-testifies-on-trump-administrations-response-to-covid-19

[110]For the purpose of this discussion, "related party" means entities controlled by the owners or controlled by other individuals who have family relationships or joint ownership of other business ventures with the facility owners.

[111]Among guidance issued in March, CDC noted that agency staffers, working in multiple location, are higher risk as disease vectors. "Facilities should identify staff that work at multiple facilities (*e.g.,* agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19." CDC, *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*, March 13, 2020.

[112]In order to enable OAG to investigate the financial transactions, related-party relationships and staffing levels in all of the facilities where insufficient staffing may be a root cause of neglect, MFCU's funding would need to be increased by over 300 percent. Such a budget increase is not one of this report's recommendations. It would be far more efficient to address the identified problem by implementing the recommendations of requiring mandatory, sufficient, defined staffing and supervision levels and more transparency in transactions between nursing homes, related parties and investors.

[113]*See, e.g.,* media reports such as projects.newsday.com/long-island/coronavirus-cold-spring-hills-nursing-home

[114]Such practices also have tax implications.

Exhibit N

EMPIRE REPORT

Debunking the Empire Center Analysis Attributing Nursing Home Covid-19 Deaths to DOH Policy

By **Paul Francis** | **September 8, 2024**

The following is excerpted from "Re-Examining the Cuomo Administration's Nursing Home Policies During Covid-19", by Paul Francis, September 5, 2024.

Four-and-a-half years after the Covid-19 pandemic began, critics of the Cuomo administration continue to make the false claim that guidance from the New York State Department of Health designed to facilitate discharges by hospitals of stable Covid-19 patients to nursing homes significantly contributed to nursing home deaths.

On Tuesday, September 10, 2024, former New York Gov. Andrew Cuomo is scheduled to testify at a hearing of the House Select Subcommittee on the Coronavirus Pandemic. The subcommittee chairman, Representative Brad

Wenstrup, Republican of Ohio, said in a statement: "Andrew Cuomo owes answers to the 15,000 families who lost loved ones in New York's nursing homes during the Covid-19 pandemic," due to "potentially fatal nursing home policies."

The "potentially fatal nursing home policies" Rep. Wenstrup is referring to were from an Advisory issued by the Department of Health on March 25, 2020. At that time, hospitals in New York were facing an unprecedented crisis as the COVID-19 pandemic quickly inundated hospitals with patients suffering from severe respiratory symptoms.

In the midst of this public health emergency, DOH issued the March 25 Advisory, which stated:

"No resident shall be denied re-admission or admission to the nursing home *solely* based on a confirmed or suspected diagnosis of COVID-19." (emphasis added)

Republicans and other critics imply that the March 25 Advisory was responsible for significantly increasing the number of deaths of nursing home residents during the Covid-19 pandemic. Intuitively, it might seem logical that transferring patients who had been treated for Covid-19 in the hospital to nursing homes would increase the spread of infection to nursing homes and thus increase the number of deaths of nursing home residents. But upon closer examination, there are important factors that contradict this intuitive belief and no credible empirical evidence to suggest that these transfers did have a measurable effect on nursing home deaths from Covid-19.

There are two important facts that help account for why these transfers did not measurably increase deaths of nursing home residents and that help explain why there is no valid empirical evidence that they did. First, Covid-19 patients discharged from hospitals to nursing homes were unlikely to continue to be infectious, given that the discharges were made after the length of time that the scientific evidence suggests patients remained contagious. Second, all but six nursing homes in New York (out of more than 600) had already had a Covid-19 case among a resident or staff member at the time of the first admission of a Covid-19 patient from a hospital.

The myth that empirical evidence supports the conclusion that the March 25 Advisory was a major cause of nursing home deaths in New York is almost entirely attributable to an analysis published by the Empire Center, a small right-of-center think tank based in Albany, in February 2021. The actual claims of the

Empire Center analysis were far more modest than the impression it created – and those claims do not hold up to scrutiny.

First, the Empire Center separately analyzed nursing homes located in downstate New York, where 93% of deaths of nursing home residents occurred, and nursing homes located upstate. The Empire Center found *no* statistically significant correlation in downstate nursing homes between admissions of Covid-19 patients from hospitals to nursing homes and deaths of nursing home residents.

Second, the Empire Center *did* find a statistically significant correlation in upstate nursing homes between admissions of Covid-19 patients from hospitals and deaths of nursing home residents. Only 27 out of 312 upstate nursing homes received such admissions during the 45-day period when the March 25 Advisory was in effect. Taken at face value, the Empire Center analysis suggested that the March 25 Advisory was "associated" with (they were careful to not say "caused by") approximately 300 additional deaths in upstate nursing homes out of 9,110 deaths of nursing home residents statewide during the timeframe considered by the Empire Center analysis.

Even though the Empire Center had concluded that there was no statistical correlation between Covid-19 admissions from hospitals and nursing home deaths in downstate nursing homes, the Empire Center combined the correlated upstate data and the uncorrelated downstate data to suggest that statewide the March 25 Advisory may have led to "possibly more than 1,000 additional resident deaths."

It is difficult to overstate the importance of the Empire Center Study in cementing the narrative that the March 25 Advisory significantly contributed to nursing home resident deaths. Predictably, despite caveats about data and causation in the Empire Center analysis, the press and critics of the Cuomo administration treated the analysis as scientific proof that the March 25 Advisory caused a significant number of Covid-19 deaths among nursing home residents – generally emphasizing the "possibly more than 1,000 deaths" statement rather than the lower "several hundred" deaths associated with the correlation analysis of data in upstate nursing homes.

The Empire Center analysis was reviewed by a data and policy analyst named John Bacheller, who criticized combining the downstate data with upstate data to generate a statewide correlation. It is common sense that it is inappropriate to combine a much larger data set, which has been determined not to be statistically significant, with a much smaller data set for which a statistically significant

correlation has been found. Bacheller noted another methodological error in the Empire Center study, which reduced his estimate of the number of deaths of upstate nursing home residents associated with hospital transfers to a range of between 205 and 310.

However, both the Empire Center and the Bacheller analysis failed to take into account facility-specific confounding factors that render invalid the Empire Center correlation analysis between hospital transfers and deaths of residents of upstate nursing homes. Based on the public record, I found that just three upstate nursing homes with Covid-19 admissions from hospitals – Loretto Health and Rehabilitation Center and Bishop Rehabilitation and Nursing Center in Onondaga County, and Father Baker Manor in Erie County – accounted for 98 nursing home resident deaths. Crucially, these three nursing homes operated separate *isolation units or facilities* for Covid-19 patients, which undermines the argument that the transfers to these facilities spread the Covid-19 infection to other residents or that these deaths were attributable to infections spread by admissions of Covid-19 patients from hospitals. I suspect that if someone were to examine the other 24 upstate nursing homes that received transfers, they would find extenuating circumstances in some of those facilities as well.

My point is not to prove that not a single nursing home death upstate could be attributed to admissions of Covid-19 patients in transfer from hospitals. That is no more possible to prove than it is to prove that other lives were saved by freeing up additional hospital bed capacity. Rather, my point is that the Empire Center's evidence of correlation is weak to begin with, and then fails to account for facility-specific factors which severely undermines the study's purported correlation of admissions from hospitals and nursing home deaths.

Given that the Empire Center analysis found no correlation between admissions and deaths of residents in downstate nursing homes, and the inherent uncertainty of an empirical analysis upstate, the Empire Center should have done more to emphasize the part of its conclusion that stated that "the March 25 memo was not the sole or primary cause of the heavy death toll in nursing homes." Instead, the Empire Center provided a numerical conclusion that, predictably, became weaponized by critics of the March 25 Advisory and the Cuomo administration.

Given the prevailing narrative, which takes as a given that the March 25 Advisory significantly increased the number of deaths of nursing home residents, it is notable that a number of official reports in New York did not express that view. These include the July 2020 DOH Report, which did not find a consistent

relationship between admissions of Covid-19 patients from hospitals to nursing homes and nursing home deaths. New York Atty. Gen. Letitia James's report in January 2021 noted that the March 25 Advisory was consistent with federal CDC guidance. The After-Action Report on Covid-19, commissioned by New York Gov. Kathy Hochul and released in June 2024, said that New York's nursing home policies during the pandemic were "consistent with universal best practices in congregate care and accurately reflected the best understanding of the scientific community at the time they were issued." And the Assembly Impeachment Investigation Report issued in November 2021 said: "We note that our investigation did not uncover evidence to suggest that the March 25, 2020 directive … increased the number of COVID-19 fatalities in nursing homes."

It is difficult to be objective and dispassionate when the subject is the loss of life of vulnerable individuals such as nursing home residents. I hope the analytical tone of this Commentary does not suggest in any way that every life lost to the Covid-19 pandemic was not a grievous loss. I often think of a comment by a Swedish physician, who said, "To die alone and out of breath is a terrible death" – as indeed it was.

Opinions about the impact of New York State's nursing home policies are strongly held and not easily susceptible to change. But as the late Sen. Patrick Moynihan is often quoted as saying, "You are entitled to your own opinion, but you are not entitled to your own facts." One hopes that this maxim will be kept in mind as this controversial issue continues to be utilized to score political points.

Paul Francis is the Chairman of the Step Two Policy Project. He served as the Director of the Budget in 2007 and as the Deputy Secretary for Health and Human Services from 2015-2020, among other positions in New York State government, before retiring in May 2023.

Exhibit O

in Coronavirus, COVID-19, Governor Cuomo, New York, New York City, Upstate New York

Was Cuomo's COVID Mandate Associated with Nursing Home Deaths? A Correction

I recently wrote about the relationship between Governor Cuomo's policy requiring nursing homes to accept new residents discharged from hospitals with positive COVID-19 test results. The policy was in place from March to early May 2020. I compared my results with those of a study by Bill Hammond and Ian Kingsbury of the Empire Center, "COVID Positive Admissions Were Correlated with Higher Death Rates in New York Nursing Homes."

Hammond and Kingsbury concluded that the Governor's policy was associated with several hundred to more than one thousand additional deaths. My analysis agreed with Hammond and Kingsbury's conclusion that the policy was related to additional deaths but found that the number was likely much lower than their estimates.

The Empire Center report found that "*the data indicate that the March 25 memo was not the sole or primary cause of the heavy death toll in nursing homes, which stood at approximately 13,200 as of early this month.*" My findings are consistent with Hammond & Kingsbury's in that regard.

I recently reviewed the data in my analysis and found that about 25% of COVID-positive admissions and deaths were inadvertently omitted. For that reason, I rebuilt the dataset and reanalyzed the data. The reanalysis led to re-

sults closer to Hammond and Kingsbury's regional findings. However, I believe that the estimates of deaths associated with the policy generated from separate regional analyses of data from the New York City Metropolitan area and Upstate provide more accurate estimates of the policy's impact. Consequently, I believe that deaths associated with the policy are lower than Hammond and Kingsbury estimated.

Because Hammond & Kingsbury's research design did not isolate deaths of residents who were COVID-positive at the time of admission from those who died as a result of the spread of infection from COVID-positive residents to others, their estimates are larger than the actual impact of the policy on COVID nursing home resident deaths. The concern that the Health Department's mandate was associated with additional deaths was primarily based on the possibility that the newly admitted COVID patients might infect other nursing home residents, despite mandated infection control requirements.

I am indebted to Bill Hammond and Ian Kingsley of the Empire Center for being transparent about their approach, providing the data from their successful Freedom of Information suit, and their willingness to discuss their findings with me.

Corrected Findings

When the Health Department required nursing homes to admit new residents who had tested positive for COVID-19 from hospitals, nearly 9,000 COVID-positive residents were admitted. The Empire Center analysis examined deaths in April and May because of the delay between COVID infections and resulting deaths. About 8,000 COVID-related deaths occurred in New York nursing homes during that period.

	Total Residents	COVID Admits	COVID Deaths
NYC Metro	61%	94%	91%
Outside NYC Metro	39%	6%	9%

Admissions of COVID-positive residents and COVID-related deaths were concentrated in the New York Metropolitan area. Although about six in ten nursing home residents in New York State were located in the New York Metropolitan area, more than 90% of COVID resident admissions and COVID-related deaths in nursing homes occurred there.

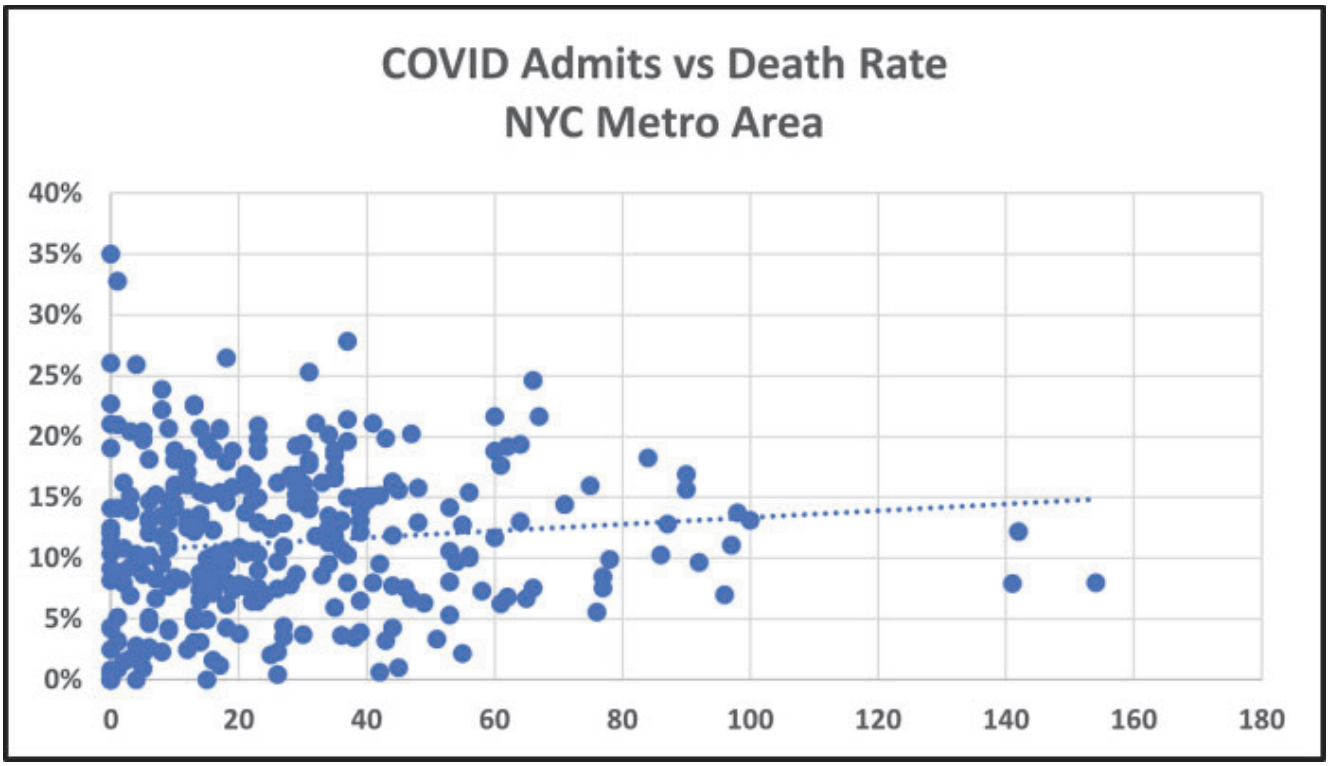
New York Metropolitan Area Findings

With the large numbers of infected metropolitan area residents, it is unsurprising that nursing homes in the region had large numbers of COVID-related deaths during the Spring of 2020. During the short seven-week period, COVID-related deaths in downstate nursing homes were equal to 11% of the region's nursing home population.

Positive test results per thousand residents in the New York City metropolitan area were more than ten times higher than outside the metro area. With more than 90% of the state's COVID-positive admissions to nursing homes and COVID-19-related deaths, conditions in New York Metropolitan area nursing homes reflected the high infection levels in the metropolitan area.

Because of the large number of infections in the metropolitan area, hospitals faced extreme crowding. More than 8,200 COVID-positive patients were discharged from metropolitan area hospitals to nursing homes during the March 25th to May 8th period.

The trend-line model included new COVID-19 admissions to nursing homes, county-level positive test rates, and the number of nursing home residents to predict the number of COVID-related deaths. In about 300 nursing homes in the New York City metropolitan area, the relationship between COVID admissions and deaths was very weak, associated with only 1% of the variables' variation.



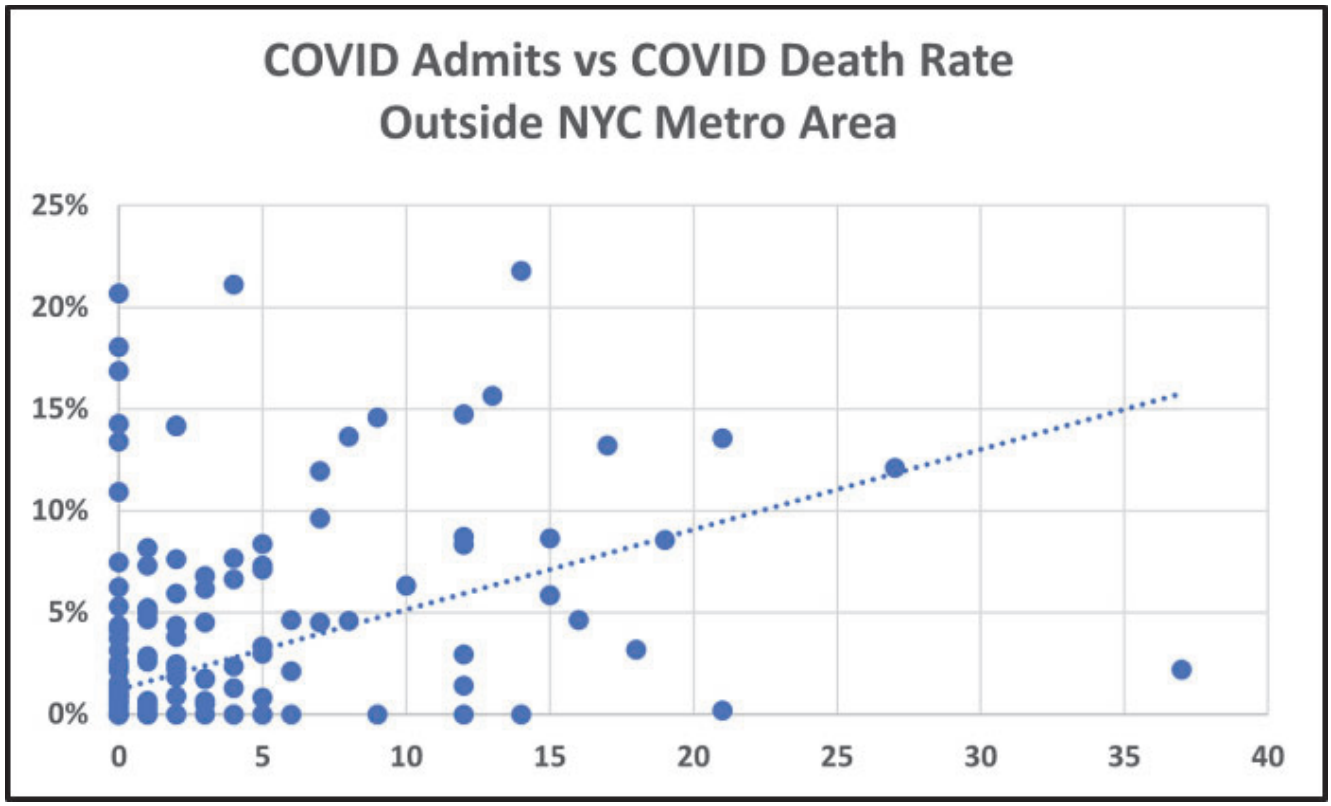
In Hammond and Kingsbury's and my earlier analyses, the relationship between COVID-positive admissions and COVID-related deaths in New York City nursing homes was not statistically significant at the 95% confidence level.

Given that the strength of the association between COVID-positive admissions is so weak—only one percent of deaths are associated with COVID-positive admissions—and that the relationship was not statistically significant, I conclude that the Health Department mandate that nursing homes accept COVID-positive residents did not result in more deaths in the New York metropolitan area.

Findings Outside the New York Metropolitan Area

The COVID-19 pandemic had a much smaller impact on upstate New York during the Spring of 2020 than in the New York City metropolitan area. Upstate nursing homes were also less affected as well. While the COVID-related death rate in the metropolitan areas was 11.2%, the rate was 1.9% in upstate New York. The state Health Department reported 730 deaths in the Upstate nursing homes studied here. Transfers of COVID-related patients were also less common. Only 532 COVID-positive patients were transferred to

Upstate nursing homes during the study period, compared to 8,200 in the metropolitan area.



Perhaps because community infection rates were much lower in Upstate New York than in the New York City Metropolitan Area, the relationship between COVID-positive admissions to nursing homes and COVID-related deaths is much more robust in Upstate nursing homes. A correlation measure between COVID admissions and COVID-related deaths shows that admissions are associated with 24% of the regional variation in fatalities.

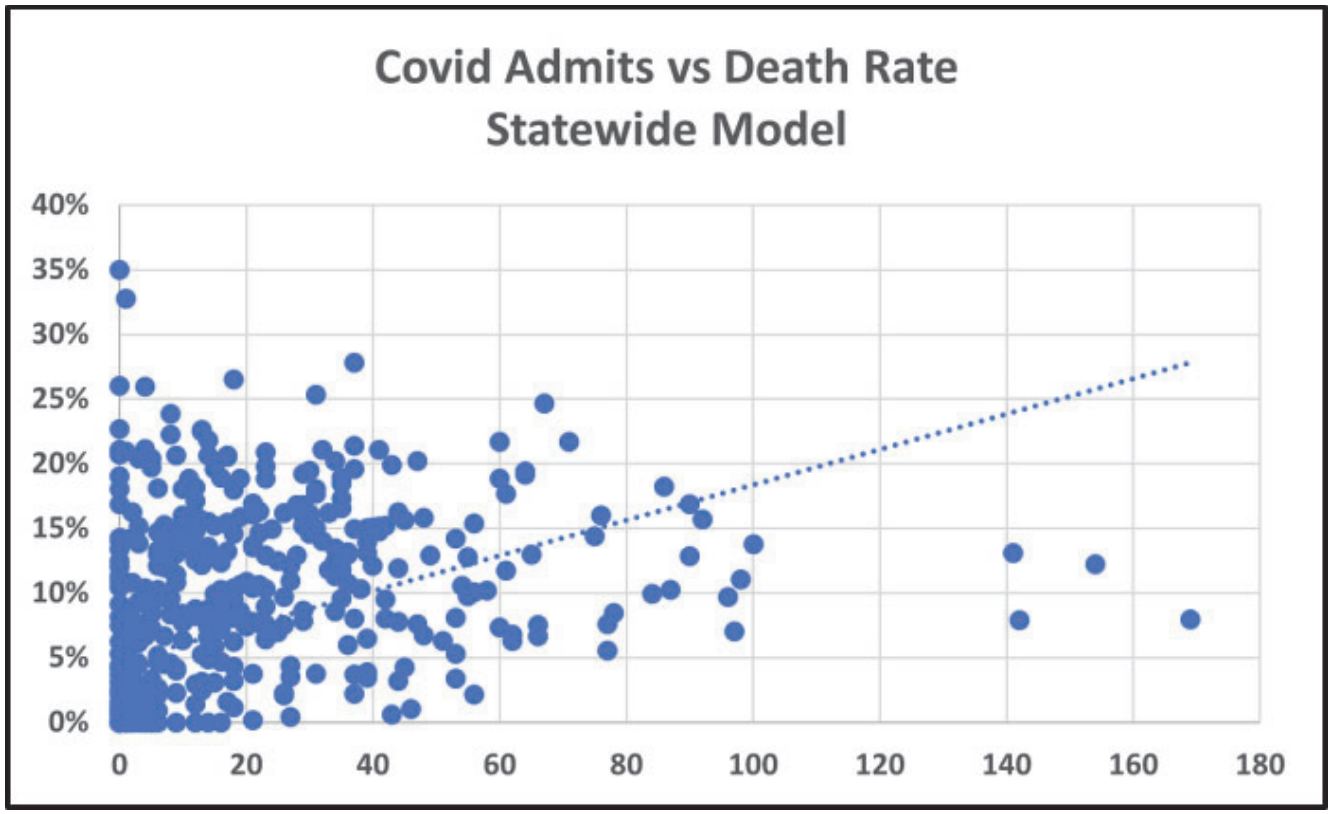
This relationship is much stronger than I found in my earlier draft from the incomplete dataset. The model estimates 283 additional deaths from the Health Department policy in upstate New York. The model predicts that the range of additional deaths with 95% certainty is 225 to 341.

The differing findings in the New York Metropolitan area and the rest of the state point to two different modes of transmission in nursing homes. In the New York metropolitan area, where more than 90% of the COVID-positive admissions and deaths took place, COVID-related deaths were unrelated to COVID admissions, pointing to staff and visitors as likely the principal means by which infection was transmitted. In upstate New York, the role of new

COVID admissions was significant, with about one-third of the 730 regional deaths associated with the Health Department mandate.

Statewide Analysis

In addition to building a regional trend-line model, Hammond and Kingsbury also created a statewide model. That model was the basis of their estimate that COVID-related deaths associated with the Health Department mandate ranged from several hundred to more than 1,000. Using the revised, corrected data and the variables I included in my analyses—number of nursing home residents, county positive tests per thousand residents, and COVID-positive admissions, the model estimated that between 1,610 and 2,463 additional deaths were associated with the State Department of Health's policy. Twelve percent of the variation in COVID-related deaths was related to COVID-positive nursing home admissions—a relatively weak relationship.



The corrected statewide data estimates that a larger number of COVID-related deaths were associated with the Health Department COVID-positive nursing home admission mandate than my earlier analysis showed. This estimate is also higher than the estimate published by Hammond and Kingsbury.

Because of the distinctive pattern of infections in New York State in the Spring of 2020, infections were highly concentrated in the New York metropolitan area. The regional models point to different transmission patterns in each region. In the downstate area, where more than 90% of COVID-related nursing home deaths occurred, the data does not show an association between the admission of COVID-positive new nursing home residents and COVID-related deaths. Upstate, a relatively strong relationship is present, with about 30% of regional deaths associated with the entry of COVID-positive residents, based on the model.

The large number of deaths that the statewide model estimates are associated with COVID-positive admissions—more than 2,000 is unlikely– given that in the region where a statistically significant relationship between admissions and deaths was present, only 730 deaths occurred.

Deaths of COVID-positive Nursing Home Residents Were Included in Study Estimates

The concerns about additional deaths that resulted from the Health Department's mandate arose from the fear that introducing residents with a transmissible disease into a nursing home setting could spread to other residents.

But, Hammond and Kingsbury's analysis does not subtract the deaths of newly admitted COVID-positive residents from their estimate of COVID deaths at the facilities. The deaths of people who were already COVID-positive could not be caused by the potentially COVID spreading effect of the Health Department mandate.

Data that breaks out the deaths of patients who were COVID-positive when admitted was not included in the information provided to the Empire Center by the State Health Department. Without that data, it is impossible to accurately measure the number of deaths of newly admitted COVID-positive residents at each nursing home.

However, there are a few published studies on the death rates of COVID patients after discharge from hospitals. A recent study published in the Journal of the American Medical Association, which dealt with patients in Veterans Administration Hospitals whose median age was between 70 and 80 years old and who were admitted before June 1st, 2020, found a death rate within sixty days of discharge of 9.1% of patients—an estimate that is almost identical to the increase of 0.09 deaths for each COVID-positive new resident admitted found by Hammond and Kingbury.

Although it is not possible to directly measure the net number of deaths of nursing home residents after excluding deaths that took place among residents who were COVID-positive when admitted, it is possible to estimate the net number of deaths by subtracting 9.1% of the number of COVID positive admissions from the number of deaths from each facility. This estimate is crude because we lack information about the actual number of deaths of COVID-positive residents, but it allows us to understand the potential impact of excluding them.

The exclusion of possible deaths of newly admitted COVID-positive residents slightly reduces the estimated deaths in Upstate nursing homes, from 283 to 258, with a range within 95% confidence limits of 205 to 310.

Conclusions

With corrected data, evidence that the Health Department's requirement that nursing homes accept new COVID-positive residents from nursing homes is stronger than I initially concluded. Based on my corrected analysis, 205 to 310 residents in upstate New York may have died from COVID-related causes when controlling for deaths of COVID-positive admitted residents. Although the number is a relatively small percentage of COVID-related nursing home deaths statewide, it is 30% of the of the approximately 700 Upstate nursing home COVID-related deaths.

While this analysis answers the question of whether COVID-related deaths in nursing homes were related to mandated COVID-positive admissions, it does

not provide information about the net impact of the policy on COVID-related deaths inside and outside nursing homes.

In the Spring of 2020, hospital facilities in the New York metropolitan area faced severe challenges related to facility, staffing, and personal protective equipment availability. Conditions were so extreme that it was difficult for COVID-positive patients to gain admission to hospitals in the New York City area.

The State Health Department's COVID admission mandate on nursing homes was a response to the hospital capacity crisis—setting up a potential policy tradeoff between deaths in nursing homes and deaths outside them.

Few policy decisions involve unambiguous benefits and no costs. This policy decision, like many others, did have both. But, at the time, it was clear that the Health Commissioner was well aware of the crisis conditions in hospitals in the New York Metropolitan area and that people were dying because of them. We still do not know whether his decision cost or saved lives overall.

Unfortunately, press coverage of the nursing home issue has focused only on the policy's effect on the number of nursing home residents' deaths. But by looking only at these deaths, press coverage, like the response of many of the state's political leaders, did not reflect the net impact of deaths inside and outside nursing homes.

Exhibit P

Paul Francis 4 days ago

Re-Examining the Cuomo Administration's Nursing Home Policies During Covid-19

Commentary # 14 by Paul Francis
September 5, 2024

Re-examining the Cuomo Administration's Nursi... .24 vFina
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Introduction

Four-and-a-half years after the Covid-19 pandemic began, people are still reckoning with nursing home policy decisions made by New York State government officials. Critics charge that the March 25, 2020, Department of Health Advisory regarding nursing home admission policies significantly contributed to the terrible death toll in nursing homes and claim that the administration's delayed disclosure of deaths of nursing home residents that occurred in hospitals was a cover-up.

At a federal level, the House Oversight Committee's Select Subcommittee on the Coronavirus Pandemic (the "House Subcommittee") continues to investigate the issue, including conducting a private deposition of former Governor Andrew Cuomo in June 2024. After the deposition, almost the entire Republican New York congressional delegation held a press conference to denounce Gov. Cuomo and New York's nursing home policies. Gov. Cuomo is now scheduled to testify publicly before the House Subcommittee on September 10, 2024.

The controversy also continues to roil in New York. In June 2024, the Olson Group, a consulting firm commissioned by the Hochul administration, released its "After Action Report on the Covid-19 Pandemic" (the "Olson Report"). Despite its criticism of certain aspects of the state's pandemic response, the Olson Report observed that New York's nursing homes' "overall outcomes were not substantially inconsistent with overall performance in such facilities nationwide"[1], and concluded that New York State's Covid-19 nursing home policies were "consistent with universal best practices in congregate care and accurately reflected the best understanding of the scientific community at the time they were issued."[2]

It is a sign of the stubborn nature of this controversy that the Olson Report did not settle the matter but simply led to calls for further investigations. New York State Comptroller Tom DiNapoli wrote an op-ed criticizing the Olson Report, which he concluded by saying: "It's time for full consideration of proposed state legislation to establish an

independent commission, with subpoena power, to provide the comprehensive accounting New Yorkers deserve."[3]

Although New York's nursing home policies during the pandemic spanned a wide range of issues from infection control to vaccinations, critics of Gov. Cuomo focus on two policy decisions. The first was a Department of Health ("DOH" or the "Department of Health") Advisory issued on March 25, 2020 (the "March 25 Advisory"),[4] that sought to free up urgently needed hospital beds by facilitating the discharge of Covid-19 patients who were stable and no longer needed hospital care. The March 25 Advisory stated that nursing homes could not deny admission or readmission "solely on the basis of a confirmed or suspected diagnosis of COVID-19." The second policy decision involved New York's practice during 2020 to report only deaths that occurred within a nursing home facility as "nursing home deaths," while reporting deaths of residents of a nursing home that occurred outside of the facility in a hospital as "hospital deaths."

The prevailing narrative of the critics was encapsulated by comments by Congressman Michael Lawler (R-NY-17) in a press conference following Gov. Cuomo's June 2024 deposition. Even by the shrill standards of today's political discourse, the venom expressed towards Gov. Cuomo in that press conference was striking. Rep. Lawler said:

> "Andrew Cuomo is a phony and a fraud…[A]t his directive, the Department of Health issued that memo [the March 25 Advisory] and he put our most vulnerable population at risk resulting in the death of over 15,000 seniors, and it was Andrew Cuomo who covered it up. It wasn't just the directive which was bad enough and idiotic and resulted in the death of the 15,000 plus seniors. It was Andrew Cuomo for political purposes who directed the state government to cover up the death toll."[5]

You would think that the passage of time would have created a more nuanced and informed view of the issues involved. But the Cuomo "nursing home scandal" is emblematic of our current state of political discourse, in which a prosecutorial mentality too often substitutes for an objective review of the evidence, facts are both distorted and conflated, and motives are invented, all while officials and staff members are demonized.

I don't want to bury the lede. As discussed in this Commentary, there is little to no evidence that the March 25 Advisory directly increased the number of deaths among nursing home residents, and many reasons to believe that it did not. It's impossible to prove the negative, that admissions from hospitals did not lead to any deaths in nursing homes, but by the same token, the March 25 Advisory may well have reduced the *total* number of deaths from Covid-19 by freeing up urgently needed hospital beds. In any event, the March 25 Advisory was an apolitical decision that was both consistent with federal guidance and supported by the public health professionals at the Department of Health.

People may question or disagree with the Cuomo administration's decision to report only in-facility nursing home deaths until February 2021, but that decision in no way affected actions on the ground that could have impacted nursing home residents. The decision to report only the more reliable number of in-facility deaths initially reflected a prioritization of accuracy in data reporting by not double counting deaths in hospitals. But in retrospect, at least after the administration's initial internal audit was completed at the end of August 2020, the administration would have been far better off reporting its estimate of total nursing home resident deaths that occurred in hospitals with

the caveat that the reconciliation process created the possibility of double counting some hospital deaths and that further analysis was required.

In any event, the *total* number of Covid-19 deaths reported was accurate and the decision to report deaths based on the facility where the death occurred was without consequence because it in no way affected the State's actions with respect to nursing homes and had no effect on nursing home resident outcomes.

The conflation of erroneous beliefs about the impact of the March 25 Advisory on nursing home resident deaths with the failure of the administration to include out-of-facility nursing home resident deaths until February 2021 is what caused the most damage to Gov. Cuomo's reputation. As stated in a perceptive article in Syracuse.com titled "Why 'Cuomo's death order' didn't really cause NY's nursing home carnage," by Tim Knauss, published on March 4, 2021, "the reality that Cuomo underreported thousands of nursing home deaths has too often blended with an unsupported assumption that his controversial March 25 directive caused those deaths."[6]

Before examining these nursing home policy issues, I need to make a disclaimer. Gov. Cuomo is one of four governors in whose administrations I served. I worked in Andrew Cuomo's gubernatorial campaign in 2010 and served in a few roles in his administration, including as the Deputy Secretary for Health and Human Services from 2015 until the summer of 2020, when I transferred to the Department of Health as a Senior Advisor. For reasons that are not particularly relevant here, I was only tangentially involved with the Covid-19 response and was not involved in the nursing home issues discussed in this Commentary.

This Commentary is based almost entirely on the extensive public record about the nursing home controversy. As with every Commentary I write for The Step Two Policy Project, I express my point of view, which is based on the facts presented. These facts are carefully sourced and referenced in the footnotes. People may disagree with my conclusions or observations, but the facts presented in this Commentary are just that – facts that can be verified and which are transparently disclosed.

"Revisionist history" is sometimes considered a pejorative term, but it is often important to challenge widely accepted views about past events that are based on inaccuracies or biases in existing accounts. That is what I hope to do in this Commentary. The prevailing narrative about the Cuomo administration's nursing home policies reflects an impression of wrongdoing or errors rather than a clear understanding of the actual underlying facts. Whether or not this Commentary changes the minds of many people, in light of the continuing controversy about this issue, I think it is important to closely examine these issues to create a more accurate historical record of the events.

The Department of Health March 25 Advisory

Background

The spread of Covid-19 in New York and the State's responses to this public health emergency have been exhaustively chronicled.[7] One is struck in reviewing these events by just how compressed the critical time period was, from March 1, 2020 when New York reported its first case, to March 25, 2020, when the number of reported cases had already exceeded 3,000 and there had been at least 200 Covid-related deaths.

The scale and speed of New York's governmental response reflected the urgency of the crisis. Governor Cuomo declared a state of emergency on March 7, 2020, followed shortly thereafter by numerous issuances of guidance and executive orders (EO), such as EO 202.1, which began to shut down activities that could contribute to the spread of the virus. On March 16, 2020, Gov. Cuomo issued an executive order that closed schools, and on March 20, 2020, Gov. Cuomo issued the "New York on PAUSE" EO that required non-essential businesses to keep their employees out of the office and encouraged individuals to stay home. Gov. Cuomo began to hold daily briefings, which focused on the surge in cases and the ever-increasing pressure on hospitals and nursing homes to manage the emergency.

Appreciating the context of what was happening in New York in March 2020 is crucial to understanding the March 25 Advisory. Hospitals in New York were facing an unprecedented crisis as the Covid-19 pandemic hit with overwhelming speed and intensity. Downstate hospitals quickly became inundated with patients suffering from severe respiratory symptoms. Emergency departments and intensive care units were overwhelmed, with many hospitals running low on oxygen and out of drugs used in critical care (including for patients on ventilators), beds, and personal protective equipment.

Hospitals were converting any available space, from corridors to cafeterias, to create capacity for inpatient beds. Covid-19 admissions continued to rise – as they would until mid-April – and there were numerous public and private projections that the need for hospital beds would outstrip even the expanded capacity. Judgments in hindsight about the wisdom of the March 25 Advisory should acknowledge the context in which it was released and what was widely expected at the time to be an extraordinary need for inpatient hospital beds. In the midst of this chaotic environment, DOH issued the March 25 Advisory, which set forth guidance regarding the criteria for admission or readmission to a nursing home, including transfers following a discharge from a hospital, of patients who had been diagnosed and treated for Covid-19. The March 25 Advisory included the following language:

> "No resident shall be denied re-admission or admission to the nursing home solely based on a confirmed or suspected diagnosis of COVID-19. (Emphasis reflects the original.) Nursing homes are prohibited from requiring a hospitalized resident who is determined medically 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."[8]

There are essentially three controversies surrounding the March 25 Advisory: (i) whether the March 25 Advisory was issued at the direction of the Governor's office, or whether it was developed by health professionals at the Department of Health; (ii) whether the March 25 Advisory *required* nursing homes to accept transfers of Covid-19 patients from hospitals under all circumstances, or whether the directive was subject to all the requirements of New York law that prohibited nursing homes from accepting residents for whom they could not adequately provide care; and, most critically, (iii) the extent to which the March 25 Advisory increased the number of deaths of nursing home residents by contributing to the spread of Covid-19 in nursing homes.

What was the Genesis of the March 25 Advisory?

The first controversy is whether the March 25 Advisory was issued by DOH at the direction of the Governor's office or developed by health professionals at DOH. The central element of the March 25 Advisory, which was to facilitate the discharge of patients who were stable and no longer required a hospital level of care, emerged from a request for guidance from the trade association of the downstate hospitals regarding transfers of Covid-19 patients to nursing homes. The details of the March 25 Advisory were informed in part by daily discussions that the hospitals were holding with staff-level officials at DOH about managing the crisis. The March 25 Advisory was part of a logical progression in a response to a public health emergency that was threatening to overwhelm hospitals, as had happened elsewhere in the world.

The controversy about the genesis of the March 25 Advisory is really beside the point, since Gov. Cuomo has strongly defended the March 25 Advisory and continues to maintain that it was the right policy decision.[9] When Gov. Cuomo testified that he was unaware of the March 25 Advisory in his private deposition to the House Subcommittee, Republican members suggested he was lying about the matter. But he would have no motivation for distancing himself from the March 25 Advisory because he has embraced the policy – as have others who were involved in the policy's development.

An important consideration of DOH staff involved determining when it was safe, from an infection prevention perspective, to discharge Covid-19 patients from hospitals when they were clinically stable and no longer needed a hospital-level of care but may have continued to test positive (because they still had detectable Covid-19 RNA).[10] The CDC began issuing interim guidance on treatment and quarantine protocols for healthcare providers to follow in January 2020. These guidance documents were continually updated to reflect the best information available.

Although the March 25 Advisory came to be seen as a critical event, in fact, it was only one of dozens of executive orders, directives, and advisories that had already been issued by DOH or the Governor's office by that time.[11]

Was the March 25 Advisory a Mandatory "Must Admit" Directive?

The second controversy – whether the March 25 Advisory *required* nursing homes to accept transfers of Covid-19 patients from hospitals under all circumstances – is more nuanced. The plain language of the March 25 Advisory does not direct nursing homes to accept Covid-19 patients under all circumstances, but rather directs that admission or readmission to the nursing home "could not be denied solely based on a confirmed or suspected diagnosis of COVID-19," while reminding nursing homes that they must maintain standard precautions.

It is also relevant that the March 25 Advisory was issued shortly after two significant guidance documents were released by the federal government. First, on March 13, 2020, CMS released additional guidance to nursing homes regarding their infection control and prevention practices to prevent the transmission of Covid-19.[12] Notwithstanding that not all nursing homes had the staffing or supplies to fully comply with the guidance, the CMS directive essentially set forth requirements for managing residents with Covid-19. With respect to the primacy of federal guidance, it should be noted that CMS regulates nursing homes, while states license the facilities and ensure their compliance with CMS regulations.

The second significant federal guidance was issued by the Centers for Disease Control and Prevention (CDC) on March 23, 2020. The primary purpose of this guidance was to facilitate transfers of asymptomatic Covid-19 patients no longer requiring hospital care to nursing homes (the "March 23 CDC Guidance"), although, as described below, it also explicitly set forth protocols to avoid transmission of infections.[13]

In addition to the plain language of the March 25 Advisory, one of the reasons DOH did not consider the March 25 Advisory to be a "must admit" order was that the policy was consistent with the March 23 CDC Guidance. Critics have emphasized that, in contrast to the general admonition in the March 25 Advisory that nursing homes needed to "maintain standard precautions" of infection control protocols, the CDC guidance provided specific instructions to prevent the spread of Covid-19 among vulnerable populations in long-term care facilities.

After stating that: "Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present,"[14] the CDC guidance then added the following language:

- "A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC infection prevention and control recommendations."
- "If a nursing home cannot implement these precautions, it must wait until these precautions are discontinued."[15]

Although critics of the Cuomo administration have placed great weight on the semantic difference between the March 25 Advisory and the March 23 CDC Guidance, the Department of Health believed that the obligation to follow infection control protocols was implicit because of requirements of nursing homes under New York law to not accept patients they were unable to properly care for, and other DOH directives issued earlier in the pandemic regarding infection control protocols.

This was reflected, for example, in guidance DOH issued on March 11, 2020, that reminded nursing homes to maintain awareness of "necessary infection prevention and control procedures by regularly visiting the CDC and NYSDOH websites," as well as reminding nursing home operators to "review and reinforce their infection control policies under New York state regulations."[16] This assumption was also reflected in the language of the March 25 Advisory in the reminder that, "[a]s always, standard precautions must be maintained."

In total, 11 other states, including California, Michigan, New Jersey, Pennsylvania, and Minnesota implemented policies substantially similar to the March 23 CDC Guidance and the March 25 Advisory. The language initially used in New Jersey was nearly identical to the March 25 Advisory statement that admission or readmission cannot be denied "solely on the basis" of the absence of a negative test for Covid-19.

Within a few weeks of the initial issuance of New Jersey's guidance, New Jersey modified the guidance to state more explicitly that the nursing home was required to have infection control protocols in place before accepting transfers or admissions of Covid-19 patients, to prevent spread of the infection. Other states, including California

and Minnesota – and by late April, New York – similarly modified their initial guidance to make this requirement more explicit. Nevertheless, there is nothing to suggest that these states, as well as New York, did not believe that the requirement of being able to properly care for transferred patients was already implicit. Rather, adding explicit language seems to have been more in the vein of reinforcement of these requirements.

In reviewing the experience of the 11 other states that similarly supported transfers of Covid-19 patients from hospitals to nursing homes based on the March 23 CDC guidance, both the criticisms of the directives and the defenses from government officials seem strikingly similar to the experience in New York. In Minnesota, for example, Department of Health Commissioner Jan Malcolm defended the policy during a Minnesota Senate hearing on the grounds that: "Staying in hospitals beyond the point where you need to be there is itself a risky thing." She said, "[we] do believe that a skilled nursing facility is the right level of care for a lot of people leaving acute [hospital] care."[17]

Minnesota Gov. Tim Walz said: "This was federal guidance… This was what everyone was doing. This was not a mistake. It wasn't like no one thought about this. There was complexity in how you deal with this."[18]

Even though the March 25 Advisory and similar guidance issued in other states were not *intended* to be mandates to accept transfers under all circumstances, it is fair to say that at least some nursing home operators viewed these directives as a mandate both in New York and elsewhere, even though that was not an accurate interpretation of the language. Roughly a month after issuing the March 25 Advisory, DOH issued revised guidance which made explicit the requirement that nursing homes must have the ability to prevent the spread of infection by maintaining infection control protocols as a precondition for the acceptance of transfers of Covid-19 patients from hospitals to nursing homes.[19] The March 25 Advisory was then superseded by new guidance on May 10, 2020.[20]

What is the Evidence About Whether the March 25 Advisory Increased Nursing Home Resident Deaths?

The third controversy – the extent to which the March 25 Advisory increased the number of deaths of nursing home residents – arguably is the one that matters most. Intuitively, it seems logical that transferring Covid-19 positive patients from hospitals to nursing homes would increase the number of cases and resulting deaths of nursing home residents. But upon closer examination, there are important factors that contradict this intuitive belief.

Overview of extenuating conditions

The first important factor that helps explain why these transfers do not appear to have increased the number of nursing home resident deaths to any measurable degree is that by the time these Covid-19 patients were discharged from the hospital and transferred to a nursing home, it is unlikely that they were infectious and thus capable of transmitting the virus. The Department of Health, in a report titled "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis" (the "DOH Factors Report"), issued on July 6, 2020, found that residents were no longer experiencing symptoms requiring hospital care and were admitted to nursing homes a median of nine days after hospital admission. According to the DOH Factors Report:

> "Health experts believe that individuals infected with the virus are most infectious 2 days before symptoms appear and that they are likely no longer infectious 9 days after symptom onset – thus, by the time these patients were admitted to a nursing home after their hospital stay, they were no longer contagious."[21]

Assuming that patients were asymptomatic for two days– and given DOH data that indicated that the median length of stay in the hospital prior to discharge was nine days – the median period of time since infection was at least 11 days. Infectiousness typically peaks around three to four days after the onset of symptoms. The average duration for which a person sheds culturable virus (i.e., is infectious) is about five days from the onset of symptoms.[22]

The second important factor that helps explain why these transfers do not appear to have increased the number of nursing home resident deaths to any measurable degree is that in all but six nursing homes (out of 610 in New York), a resident or staff member of the nursing home receiving such patients had already been infected with Covid-19, which introduced the virus to the nursing home. An update to the DOH Factors Report, issued on July 17, 2020, reviewed the nursing homes that received a transfer of a Covid-19 patient and found the following:

> "The new analysis shows that 304 of the 310 nursing homes [that received a transfer or other admission of a Covid patient who was not a returning resident] – or 98 percent – already had a suspected or confirmed COVID-positive resident, COVID-related confirmed or presumed fatality, or worker infected prior to admission of a single COVID-positive patient. Again, this means that for 98 percent of the facilities, the admission did not introduce COVID-19 into the nursing home because it was already present.[23]

> "Of the six nursing homes that admitted a patient before there was a COVID infection of staff or residents, or fatality in that facility, in all but two cases, the timing of the subsequent Covid infection made it "highly unlikely that the admission [or transfer] caused the infection or fatality."[24]

A third factor that could help explain why the transfer of Covid-19 patients from hospitals does not appear to have measurably increased nursing home resident deaths is that many nursing homes in New York – having already experienced outbreaks of Covid-19 – were already engaged in implementing infection control protocols, such as "cohorting" Covid-19 patients, which would minimize the spread of infection if any of the Covid-19 patients who were discharged from hospitals to the nursing home remained contagious.

Empirical Studies – The DOH Factors Report

As far as I am aware, there have only been three studies that sought to determine the impact on nursing home deaths in New York of admissions of Covid-19 patients pursuant to the March 25 Advisory. These are the DOH Factors Report, a study conducted by Bill Hammond of the Empire Center (the "Empire Center Study"), and the third was a review of the Empire Center Study by a retired professor and government official named John Bacheller, who empirically analyzes public policy issues on his website called "Policy by Numbers: Data For Evidence-Based Policy."[25]

The DOH Factors Report was prepared in response to criticisms of the March 25 Advisory.[26] The main conclusion of the DOH Factors Report was that: "Admission policies were not a significant factor in nursing home fatalities;" and, "The data do not show a consistent relationship between admissions and increased mortality."[27] The DOH Factors Report based its conclusion primarily on two observations. First, the fact that deaths in nursing home facilities peaked prior to the time that admissions stemming from the March 25 Advisory could have contributed to nursing home deaths; and the fact that the Covid-19 virus was already present in all but six of the nursing homes that received a transfer or made a resident admission pursuant to the March 25 Advisory.

The DOH Factors Report came under heavy criticism when the New York Times reported that the final version released to the public had been edited by individuals in the Executive Chamber. [28] The exact changes made in the editing process are not publicly known. Both the Assembly Impeachment Investigation Report and the Office of the State Comptroller Audit ("OSC Audit") (discussed below), described tensions that had developed between DOH staff and the Executive Chamber during the response to the pandemic. These tensions were reflected in the preparation of the final DOH Factors Report. According to the Assembly Impeachment Investigation Report: "While many of the DOH employees' most pressing concerns regarding drafts of the DOH Report were addressed prior to publication, other concerns with the nature of the DOH Report remained."

However, based on the Assembly Impeachment Report, the substantive difference between the initial DOH document and the final DOH Factors Report appears to have been whether to disclose out-of-facility nursing home deaths, which would have increased total nursing home deaths from approximately 6,500 to an estimate of approximately 10,000. The Assembly Impeachment Investigation Report took pains to point out that its investigators found no one at DOH who challenged the central conclusion of the DOH Factors Report that asymptomatic infections among nursing home staff were the primary cause of nursing home infections.

The Executive Chamber's mere involvement has been used to discredit the DOH Factors Report. This is unfortunate, because its involvement did not affect the conclusion that the March 25 Advisory was not a significant factor in nursing home resident deaths and that there was no consistent relationship between admissions of Covid patients and nursing home deaths. Moreover, the Executive Chamber's involvement did not affect the most important fact disclosed in the DOH Factors Report, which was that Covid-19 was already present in all but six nursing homes in New York State that received a transfer of a Covid-19 hospital patient – a fact that is undisputed.

Empirical Studies – Bill Hammond's Empire Center Study

The second study that sought to empirically identify the impact of the March 25 Advisory on nursing home deaths was written by Bill Hammond of the Empire Center, with the assistance of a statistician named Ian Kingsbury. The study was published on February 18, 2021, in a blog post titled "COVID-positive Admissions Were Correlated with Higher Death Rates in New York Nursing Homes" (the "Empire Center Study").[29]

I have known Bill Hammond since 2007, when he was writing a column on New York State government for the New York Daily News. Bill is among a small fraternity of researchers who generate sophisticated analyses about New York State government policy issues. To his credit, Bill shared with me the data on nursing home admissions and readmissions during the period that the March 25 Advisory was in effect. DOH released this information to the

Associated Press through a FOIL request but has not made the data publicly available. The Empire Center study made Bill an important participant in the New York nursing home controversy.

Bill Hammond's later testimony before the House Select Subcommittee on August 17, 2021,[30] reads like a prosecutorial brief and reflects the extent to which he views the March 25 Advisory and the delay in reporting out-of-facility nursing home resident deaths as two sides of the same coin. He leaves no room for reasonable alternative interpretations that explain the administration's actions and decisions. Hammond's testimony suggests that his suspicions about the connection between these two policies were deepened by his inability to get information about nursing home deaths by facility pursuant to FOIL requests, which led to a court order directing DOH to release more information.

The actual conclusions of the Empire Center Study were far more modest than the impression it created. The Empire Center Study found that "transfers from hospitals to nursing homes were *not* significantly associated with nursing home deaths *downstate* (emphasis added), "where the population-wide infection rate was exceptionally high during the period in question."[31] The Empire Center Study did, however, conclude that there was a correlation between admissions from hospitals to nursing homes and subsequent fatalities in upstate nursing homes.[32] Only 27 out of 312 nursing homes upstate (defined by Hammond as the 54 counties north of New York City, Nassau, Suffolk, and Westchester) received a total of 509 new admissions from hospitals of patients who had been treated for Covid-19during the 45-day period that the March 25 Advisory was in effect. Specifically, based on a regression analysis, the Empire Center Study found that in upstate nursing homes, "each new admission of a COVID-positive patient correlated with 0.62 *additional* deaths, with a margin of error of plus or minus 0.17."[33] (Emphasis added)

Taken at face value, this analysis suggested in the study concluded that for every 100 transfers during the period from March 25 through May 8, there would be 62 additional deaths (subject to the margin of error) between April 12 and June 4 (the period of time during which deaths associated with admissions under the March 25 Advisory would have occurred) than would have been the case in the absence of such admissions – or approximately 300 additional deaths out of the 9,110 nursing home deaths (including out-of-facility deaths) that occurred in New York between April 12 and June 4.

The Empire Center Study acknowledged the limitations of its analysis, writing:

> "As with any such analysis, the results should be viewed with caution. Even a statistically significant correlation between two factors does not necessarily mean that one caused the other. The available data were also limited in potentially important ways.... possibly relevant factors, such as the relative quality of care provided in the nursing homes and the average acuity of their patients' condition, were beyond the scope of this review."

But given how small the sample size is for the Empire Center Study's conclusion, there were other confounding factors that influence the result. One anomalous factor that is known from public reporting is that at least two of the nursing homes in Onondaga County, which collectively accounted for more than 10% of the upstate deaths in nursing homes that receive Covid-19 admissions, had separate isolation facilities for Covid-19 patients. As reported on Syracuse.com:

> "Bishop and Loretto – the two facilities that took in hospital patients – accounted for 46 deaths. Both nursing homes had established separate units in their buildings where Covid-19 patients were isolated with negative-pressure ventilation to prevent the virus from spreading....
>
> "We were already well-prepared and had an environment to care for our residents safely, so we did not see a significant spread in our facility," [Julie Sheedy, a Loretto official], said.
>
> "Bishop had 42 deaths, the most among the eight facilities. But Bishop also actively worked with hospitals to admit Covid-19 patients at its isolation unit, according to previous news reporting. Many of the patients transferred to Bishop were not expected to survive, making the facility something of a Covid hospice. That may partially explain its high death count."[34]

Another outlier in the upstate data involves the Father Baker Manor nursing home in Erie County, which is part of the Catholic Health System of Western New York (the "Catholic Health System"). The Catholic Health System converted a closed nursing home facility called St. Joseph's Post-Acute Care Center and operated it as a Covid-only nursing home under the license of Father Baker Manor. Of the 78 deaths recorded under the Father Baker Manor license during the relevant March 25 Advisory time period, 48 actually occurred at the St. Joseph's Covid-only nursing home.[35]

In total, out of the approximately 300 deaths in upstate nursing homes that the Empire Center Study analysis suggested were associated with the March 25 Advisory, 98 such deaths occurred in isolation units or facilities at these three nursing homes in Onondaga and Erie County, which makes it highly unlikely that these deaths were attributable to transmission of infections from other nursing home residents who had been admitted from hospitals with Covid-19. If a review was conducted of the other 24 upstate nursing homes that received Covid-19 admissions, some of them may also have had practices that undermine the hypothesis that the admissions resulted in deaths of other nursing home residents.

The point is not to prove that not a single nursing home death upstate could be attributed to admissions of Covid-19 patients transferred from hospitals. Rather, it is to suggest that the evidence of correlation is weak at best, and in a number of cases, there were facility-specific factors and other causes that suggested that the nursing home resident deaths were unrelated to Covid-19 admissions under the March 25 Advisory.

Given that the Empire Center Study found no correlation between admissions and deaths in downstate nursing homes and the inherent uncertainty of an empirical analysis upstate, the Empire Center Study could have done more to emphasize the part of its conclusion that "the March 25 memo was not the sole or primary cause of the heavy death toll in nursing homes." Instead, it drew a conclusion that, on a statewide basis, the March 25 advisory was "associated with several hundred and possibly more than 1,000 additional resident deaths." The Empire Center Study does not explain how it arrived at such a statewide estimate when it concluded that downstate nursing home deaths were not statistically correlated with admissions of Covid-19 patients from hospitals.

It is difficult to overstate the importance of the Empire Center Study in cementing the narrative that the March 25 Advisory significantly contributed to nursing home resident deaths and, especially, that the decision to report only in-facility nursing home deaths was a cover-up. By putting a specific number on the number of deaths "associated" with admissions of Covid-19 patients from hospitals – knowing that despite all the data caveats, the statement would be interpreted as proof of causation – the Empire Center study purposefully created an impression of certainty that was unwarranted and which quickly became a central part of the narrative about the March 25 Advisory.

The New York Post headline read, "Cuomo policy may have led to over 1,000 nursing home deaths, watchdog says."[36] Predictably, the Empire Center's caveat about the reliability of its correlation analysis was repeated deep within the story.

In the Wall Street Journal, the opinion writer James Freeman wrote: "The Empire Center's new analysis of long-hidden data suggests that a key Cuomo policy had disastrous results in the spring of 2020." He added that:

> "The governor has presented the scandal as simply a debate about the way deaths were categorized, while rejecting the notion that his policies increased mortality. His position will be harder to maintain after Thursday's release of a new study from New York's Empire Center for Public Policy."[37]

Empirical Studies – John Bacheller's Review of the Empire Center Study

John Bacheller developed his own statistical analysis of the correlation between admissions of Covid-19 patients from hospitals during the time the March 25 Advisory was in effect and also reviewed the Empire Center Study.[38] Although his analysis received little attention, it is a valuable independent and statistically-based study of the effect of the March 25 Advisory. Given that most people aren't familiar with Bacheller's analysis, I will extensively quote directly from his analysis here.

To begin with, Bacheller also arrived at the conclusion that there was no statistically significant correlation between the March 25 Advisory and deaths of nursing home residents in the downstate region. He wrote:

> "Given that the strength of the association between COVID-positive admissions is so weak—only one percent of deaths are associated with COVID-positive admissions—and that the relationship was not statistically significant, I conclude that the Health Department mandate that nursing homes accept COVID-positive residents did not result in more deaths in the New York metropolitan area."[39]

Bacheller also undermined the validity of the Empire Center Study statewide model, which was the basis for the conclusion that the March 25 Advisory "possibly resulted in 1,000 deaths or more – which was the number the press and other critics had latched on to." Bacheller wrote that the larger number of deaths was "unlikely" given the very weak strength of the association in downstate nursing homes when compared to the number of deaths in the upstate region where there was a statistically significant correlation.

Bacheller noted a methodological flaw in the Empire Center Study, which was that:

> "Hammond and Kingsbury's analysis does not subtract the deaths of newly admitted COVID-positive residents from their estimate of COVID deaths at the facilities. The deaths of people who were already COVID-positive could not be caused by the potentially COVID spreading effect of the Health Department mandate."

With this adjustment, Bacheller wrote: "The exclusion of possible deaths of newly admitted COVID-positive residents slightly reduces the estimated deaths in Upstate nursing homes, from 283 to 258, with a range within 95% confidence limits of 205 to 310."[40]

It should be noted, however, that Bacheller's analysis did not take into account the confounding factor of 98 deaths in just three nursing home facilities that had separate isolation units or facilities, which casts doubt on the validity of even his lower estimate of upstate nursing home deaths associated with the March 25 Advisory.

Part of the challenge in fairly assessing the impact of the March 25 Advisory is that information that could shed light on the issue has not been made public by the Department of Health. To the extent that the impact of admissions pursuant to the March 25 Advisory continues to be a focal point of the nursing home policy controversy, DOH should release this data and add it to the already existing Covid-19 nursing home data available on the DOH website. DOH should also make public the original paper that was written by DOH public health staff members (with the assistance of McKinsey & Co.) that served as the foundation for the DOH Factors Report.

What did Official Reports Say about the Impact of the March 25 Advisory?

Notwithstanding the intensity of criticism of the March 25 Advisory among elected officials and the press, official reports on New York's nursing home policies during the Covid-19 pandemic either did not find fault with the March 25 Advisory or were muted in their criticism. For example, the January 2021 report by New York Atty. Gen. Letitia James, titled "Nursing Home Response to [the] Covid-19 Pandemic" (the "January OAG Report), stated that "government guidance [i.e., the CDC guidance and the March 25 Advisory] *requiring* the admission of COVID-19 patients into nursing homes may have put residents at increased risk of harm in some facilities…." (Emphasis added.) It should be noted again that the March 25 Advisory did *not* require the admission of Covid-19 patients into nursing homes, but rather said that admission could not be denied solely on the basis of a Covid-19 diagnosis.

Notwithstanding the comment that guidance from CDC and DOH "may have put residents at increased risk of harm in some facilities, the January OAG Report made the following observation regarding the criticism of the March 25 Advisory:

> "[T]he March 25 guidance was consistent with the CMS guidance on March 4 that said nursing homes should accept residents they would have normally admitted, even if from a hospital with COVID-19, and that patients from hospitals can be transferred to nursing homes if the nursing homes have the ability to adhere to infection prevention and control recommendations….

> "It is worth noting that to the extent New York hospitals had capacity concerns due to the pandemic, the March 25 guidance would have been helpful to communities where those facilities were experiencing longer COVID-19 patient stays due to delays in receiving testing results, and were at or exceeding acute care capacity while they simultaneously were anticipating more new patients in need of acute care. This is because many hospitals in areas of high COVID-19 infection rates in some other states reported that "post-acute facilities were requiring negative COVID-19 tests before accepting patients discharged from hospitals." This practice meant that some patients who no longer required acute care were occupying valuable hospital beds while waiting to be discharged."[41]

Another official assessment of the impact of the March 25 Advisory (ironically) is the November 2021 New York State Assembly's "Impeachment Investigation Report to Judiciary Committee Chair Charles Lavine and the New York State Assembly Judiciary Committee," (the "Assembly Impeachment Investigation Report"), which stated:

> *"We note that our investigation did not uncover evidence to suggest that the March 25, 2020 directive, which addressed the admission or readmission of nursing home residents who had been diagnosed with COVID-19 (the "March 25 Directive"), increased the number of COVID-19 fatalities in nursing homes* (emphasis added). Similarly, based on our investigation – which did not involve an independent medical assessment – we are not aware of any evidence that undermines the central conclusion of the DOH Report that COVID-19 was likely introduced into nursing homes by infected staff. We note that many of the decisions regarding the pandemic and related policies were made in the context of a once-in-a-century event that was fastmoving and presented significant challenges."[42]

Reporting of Nursing Home Deaths

Background

The second branch of the controversy surrounding the Cuomo administration's nursing home policy during the Covid pandemic is the assertion that the number of nursing home deaths in New York was misrepresented by including only deaths within nursing home facilities as "nursing home deaths," while counting deaths of nursing home residents in hospitals as "hospital deaths." As with the March 25 Advisory, there's a good deal of conflation of facts surrounding the issue of the reporting of nursing home deaths, with minor and temporary inaccuracies in the reporting of nursing home deaths in nursing home facilities being conflated with the methodology decisions of whether to include, first, "presumed" as well as "confirmed" deaths, and then whether to include out-of-facility deaths of nursing home residents.

This conflation created the impression that the Cuomo administration sought to downplay the number of nursing home deaths from the beginning of the pandemic. In reality, the Cuomo administration was intensely focused on providing real-time data on Covid-19 deaths. Unsurprisingly, however, new data collection systems that were built on the fly, combined with the reliance on reporting from overstretched nursing home and hospital staff, led to data integrity issues (including whether a nursing home resident had died in the hospital) that persisted into the summer of 2020. Even so, to some extent in August 2020, enough reconciliation had been performed that DOH would have been able to provide a fairly accurate estimate of the number of out-of-facility deaths.

In hindsight, given the damage caused by the perception that New York's convention of reporting nursing home deaths was a cover-up designed to make New York's performance involving nursing homes look better and to diminish the perceived impact of the March 25 Advisory, the Cuomo administration clearly would have been wiser to provide an estimate of the number of nursing home residents who died in hospitals with the appropriate caveats about data limitations.

Gov. Cuomo said as much when the controversy metastasized in early 2021. At a press conference on February 15, 2021, weeks after the release of the OAG Report, he acknowledged that the administration should have released "as much information as we could as quickly as we could."[43] He later "conceded that the failure to answer questions from state lawmakers and the news media had created a void 'filled with skepticism, and cynicism, and conspiracy theories which furthered the confusion.'"[44]

What gets lost in the rehashing of the reporting decision and speculation about motives for the decision is that no one has plausibly argued that New York's reporting convention in any way affected actions on the ground or understated the *total* number of Covid deaths in New York. Instead, this self-inflicted wound has been weaponized to support the false impression that the administration's actions significantly contributed to the nursing home death toll in New York.

Finally, if the decision to only count in-facility nursing home resident deaths was a cover-up, it was a cover-up conducted in plain sight. As described below, there was no deception that New York was only including in-facility nursing home resident deaths. Instead, there was great frustration on the part of elected officials and the press that New York was not disclosing at least its best estimate of the number of out-of-facility nursing home resident deaths.

This frustration led to a contentious New York State Senate hearing in early August 2020 in which DOH officials declined to provide any estimate of the number of out-of-facility deaths and the subsequent written request for the information. On August 26, the US Department of Justice sent a letter to New York and three other states with Democratic governors (New Jersey, Michigan and Pennsylvania) that had a nursing home admission criteria directive similar to New York's, requesting additional information on nursing home fatalities. And by Thanksgiving, the second wave of Covid-19 arrived in New York and the administration began a massive rollout of a Covid-19 vaccine.

Although the nursing home controversy was bubbling below the surface in late 2020, it was three pivotal events in early 2021 that established the damaging narrative that plagues Gov. Cuomo to this day. The first event was the report on Covid-19 and nursing homes released by the New York State Attorney General in January 2021. That was followed by the publication by the New York Post on February 11, 2021, of a leaked transcript of a Zoom call with legislators that discussed the administration's reasons for delaying the release of data on nursing home deaths. This was followed by the publication of the Empire Center study on February 17, 2021, which would cement the narrative of a connection between the March 25 Advisory and the decision to delay releasing the number of out-of-facility nursing home deaths.

The 2021 Office of the Attorney General Report

The investigative nature of the report of the OAG Report, which estimated the number of out-of-facility nursing home deaths as being roughly 50% of the number of in-facility deaths, heightened the perception that data was being hidden and triggered a firestorm of criticism of the administration.

The primary focus of the OAG Report was to analyze potential contributors to nursing home deaths, such as noncompliance with infection control protocols, quality ratings, and personal protective equipment and staffing shortages. But what registered with the public was the OAG Report's estimate of out-of-facility nursing home deaths (based on a survey of about 10% of New York's nursing homes) and a linkage to the March 25 Advisory that included a highly inaccurate and misleading statistic.

The OAG Report said that based on "DOH publicized data, 4,000 nursing home deaths occurred after the issuance of the March 25 guidance, including some in 323 facilities that apparently had no reported COVID-19 infections before receiving admissions or re-admissions of hospital residents who had been diagnosed with COVID-19."[45] In fact, based on the DOH Factors Report, only *six* nursing homes had no reported Covid-19 infections before receiving admissions or re-admissions of hospital residents who had been diagnosed with Covid-19.

The OAG Report triggered an avalanche of press coverage that featured the misleading narrative that the Cuomo administration's reporting convention was a cover-up related to the March 25 Advisory, which seemed to confirm the worst suspicions of critics of the Cuomo both about the March 25 Advisory and its unwillingness to disclose the estimated number of out-of-facility deaths of nursing home residents.

A New York Post story was typical of press coverage. It said:

> "The report further notes that at least 4,000 residents died after the state issued a controversial, March 25 Cuomo administration mandate for nursing homes to admit "medically stable" coronavirus patients — which James said 'may have put residents at increased risk of harm in some facilities.'"[46]

Zoom call with state legislators

Following the release by DOH of the total number of nursing home deaths (including out-of-facility deaths) on February 3, 2021, top aides of Gov. Cuomo held a Zoom call with State legislators to answer a wide range of questions, including why the administration had taken so long to provide this information to State legislators pursuant to their August 2021 information request.

Cuomo's top aide responded by saying that the administration deferred providing data on the total number of nursing home deaths by facility to the legislature because it was prioritizing the DOJ request and was concerned that any inconsistencies in the data would be used against New York in a politically motivated investigation by the Trump administration. The suggestion that the administration was holding onto this information – for whatever reason – was sharply criticized.

The Release of the Empire Center Study

As described above, when the Empire Center Study was published on February 17, 2021, it seemed to establish a motive for the delay in releasing information. Critics also seized on a contract Gov. Cuomo had entered into in 2020 for a book on New York's response to the Covid-19 pandemic as yet another motive for not disclosing information that could reflect badly on the administration's decisions during the pandemic.

The combination of these factors turned the controversy over these nursing home policy decisions into a full-blown scandal. CNN reported that the US Attorney's office for the Eastern District of New York and the FBI had launched an investigation into the reporting of nursing home deaths[47] – investigations that came to nothing after extensive interviews of DOH and Executive Chamber staff, but still generated the type of speculation and reputational damage that always accompanies a law enforcement investigation.

Although Gov. Cuomo's approval ratings remained strong, the blood was now in the water. CNN reported: "Cuomo's rivals in the increasingly progressive state legislature, which is now home to Democratic supermajorities in both chambers, have been emboldened by the growing sense of scandal."[48]

It has long been remarked that since Watergate, the press views all issues through the prism of scandal and controversy, and that has become only truer over time. The prism of scandal through which the New York nursing home policy issues came to be viewed obscured the real stakes involved. The specific facts regarding these nursing home policy decisions became lost in a fog of perception that something wrong had been done and that someone – in this case Gov. Cuomo – should be held responsible for some of the pain of Covid-19.

Although issued after Gov. Cuomo's resignation in August 2021, two other official reports are an important part of the factual record regarding the Cuomo administration's actions and decisions with respect to these nursing home policies.

Impeachment Investigation Report to the New York State Assembly Judiciary Committee

The Impeachment Investigation Report, prepared by the prominent law firm Davis Polk & Wardwell LLP and issued on November 22, 2021, is significant both with respect to the March 25 Advisory and the issue of reporting nursing home deaths. As quoted above, the report made clear that Davis Polk did not find evidence that the March 25 Advisory had an impact on nursing home deaths, nor did it find that "any Executive Chamber, Task Force, or DOH employee with whom we spoke disagree[d]" with the "central conclusion of the DOH [Factors] Report that COVID-19 was likely introduced into nursing homes by infected staff."[49]

With respect to the reporting of nursing home resident deaths, the Impeachment Investigation Report sought to "assess whether the former Governor directed his staff to inappropriately withhold or misrepresent information regarding the effects of COVID-19 on nursing home residents in New York."[50] The report acknowledged that the DOH Factors Report "labeled the 'nursing home' fatalities as including 'confirmed and presumed fatalities, NH population only in NH facilities,'" but then concluded that:

> "Although the description of the data was technically accurate, the DOH [Factors] Report could have been more transparent regarding the number of nursing home residents who had died as a result of COVID-19, by either disclosing out-of-facility deaths or explaining why those deaths were not included in the report."[51]

Given its conclusion that the DOH Factors Report was accurate but "could have been made more transparent," the only way in which the nursing home issue could have supported a narrative for impeachment is if the investigation found that the failure to be transparent was essentially a cover-up. On this issue, Davis Polk & Wardwell found that DOH officials wanted to disclose the higher number that included out-of-facility deaths in July or August 2021, while the Executive Chamber wanted to publicly report only confirmed and presumed resident deaths within the nursing home facility. On the crucial question of motivation, the Impeachment Investigation Report said:

> "Certain witnesses have explained that there are multiple possible reasons for choosing to report in-facility deaths only, including questions regarding the reliability of data regarding out-of-facility deaths, which was more difficult to collect and verify than data regarding in-facility deaths. [O]ther witnesses explained that a reason for including in-facility deaths only was because including the higher number would have distracted from the overall message of the DOH Report and would have also been inconsistent with data that had been publicly reported at the relevant time."[52]

Whether the decision to delay reporting out-of-facility deaths was simply to prioritize data integrity by not reporting any numbers that had not been fully reconciled to avoid double counting or other inaccuracies, or to help shape public perceptions of the Cuomo administration's nursing home policies, it was a fateful decision that did not work in the administration's favor.

The 2022 Audit by the Office of the State Comptroller

The most extensive review of the Cuomo administration's policy with respect to reporting nursing home deaths is the Audit by the Office of the State Controller titled "Use, Collection and Reporting of Infection Control Data"(the "OSC Audit"), issued on March 15, 2021.[53] The OSC Audit ostensibly was focused on whether, during the period from January 2017 through November 2021, DOH was collecting necessary data to make informed decisions about infection control policies, as well as "whether the data collected by the department, including data reported to the public [was] accurate and reliable."

Although the primary focus of the OSC Audit purported to be whether DOH data collection and analysis processes *prior* to the Covid-19 pandemic would have enabled the State to better respond to the crisis, the audit report soon makes clear that its primary interest is in criticizing the Cuomo administration's policy of limiting its reporting of nursing home deaths to deaths within the nursing home facility.

The OSC Audit made much of data errors in the earliest part of the Covid-19 pandemic, when DOH was relying on telephonic communication with nursing homes to understand the death count in nursing homes in something close to real time. The Audit did not seem to accept the explanation of DOH officials with respect to both data errors and changes in methodology during the first 10 weeks of the pandemic that:

> "'[A]t that time, the numbers were constantly changing due to the frequent reconciliations being performed on the number of deaths reported, and that the numbers reported publicly were the deaths that had been reconciled with external data.'"[54]

The Department of Health forcefully responded to the findings and conclusions of the OSC Audit in its official "Comments" on the audit (the "DOH OSC Comments"). It is important to remember that by the time DOH was responding to the OSC Audit, Gov. Cuomo had resigned and DOH was submitting its comments under the auspices of the Hochul administration.
The DOH OSC Comments pointed out that:

> "The draft report does not address the practical challenges that the department... [e]ncountered from the earliest days of the Covid-19 pandemic to gather time sensitive in comprehensive infection, mortality and personal protective equipment information that was not available using the traditional data collection methods historically used to monitor and combat infectious diseases or track mortality data.... The department was required to make pragmatic decisions to meet the need for daily, real time information and the department moved quickly to repurpose and augment New York's existing systems to gather the information it needed from nursing homes and hospitals."[55]

If you put aside the issue of whether the Cuomo administration chose to report nursing home deaths in the way that it did to make its nursing home performance look better, the central question is whether not counting deaths of nursing home residents outside of the nursing home (almost always in hospitals) had an impact on State actions on the ground.

The DOH OSC Comments asserted that OSC was implying that its data collection and analysis practices both prior to and during the Covid-19 emergency, to which OSC, in its official reply to the DOH OSC Comments, by saying:

> "[T]he report does not state or imply [that] 'the collecting data in a different manner prior to the pandemic's outbreak or public reporting that information differently during the pandemic could have altered the course of the pandemic in New York.' Rather, we state...throughout the report, that better data analysis and data reliability efforts might have allowed the department more effectively use resources at its disposal for day-to-day operations and in response to public health emergencies."[56]

The DOH OSC Comments later added:

> "[W]hile the draft report criticizes the prior [Cuomo] administration for a lack of transparency, and not disclosing more information, none of the reports that were made to the public under the department's purview are false or inaccurate, as the Draft Report now implies. All reports issued by the Department plainly identified the data sources they included and were accurate, a fact that the New York State Assembly's investigative report has acknowledged."[57]

OSC's response to this DOH Comment was simply: "We found that the reports of deaths were inaccurate for the period April 15 to May 2, 2020."[58]

Conclusion

There have been few issues in New York State government as heated as the controversy regarding the Cuomo administration's nursing home policies during the Covid-19 pandemic – specifically the March 25 Advisory and the decision until February 2021 to include deaths of nursing home residents in hospitals under "hospital deaths" rather than "nursing home deaths."

Most of the underlying facts are not in dispute. What is in dispute is the interpretation of those facts: most critically, the extent to which the March 25 Advisory and the nursing home death reporting convention were *consequential* in terms of the State's Covid-19 response and the extent to which the March 25 Advisory resulted in additional deaths of nursing home residents.

It is difficult to be objective and dispassionate when the subject is the loss of life of vulnerable individuals such as nursing home residents. I hope the analytical tone of this Commentary does not suggest in any way that every life lost to the Covid-19 pandemic was not a grievous loss. I am often reminded of a comment by a Swedish physician, who said, "To die alone and out of breath is a terrible death" – as indeed it was.

But given the intensity of the ongoing controversy, it is important to dispassionately review the public record about these issues. It is important to be reminded that *no one* who has studied this issue has concluded that the March 25 Advisory accounted for more than a small percentage of deaths of nursing home residents in New York. This Commentary reviews evidence and analyses that suggest that reaching any numerical conclusion about the March 25 Advisory directly leading to additional nursing home deaths is unwarranted.

With respect to the controversy regarding the delay in reporting out-of-facility deaths of nursing home residents, the critical issue for me is that no plausible case has been made that the State would have acted any differently with respect to nursing homes if it had been reporting out-of-facility resident deaths under nursing home deaths from the beginning of the pandemic. And the fact remains that the *total* number of Covid-19 deaths reported by the Cuomo administration was fully and accurately recorded between nursing home and hospital deaths, which has never been in dispute.[59] Although the delay in reporting out-of-facility deaths of nursing home residents was damaging because it created the perception that something wrong has been done that was now being covered up, it simply had no impact on the facts on the ground.

In hindsight, it's hard not to see the Cuomo nursing home scandal as a kind of perfect storm with cascading events.

- The March 25 Advisory seemed to create a scapegoat for the tragedy of thousands of nursing home deaths.
- The reluctance of the Cuomo administration to report out-of-facility nursing home resident deaths for fear of reporting a number that could later prove inaccurate became a self-inflicted wound, since by the summer of 2020, the administration would have been better served by releasing its best estimate of the total number of nursing home deaths.

- The manner in which the approximate number of nursing home deaths became public – an "investigation" by the Attorney General – coupled with the release of the Empire Center Study, which created the impression that the March 25 Advisory caused many nursing home deaths, appeared to create a motive for why the Cuomo administration would "cover-up" the total number of nursing home deaths.
- The fact that Gov. Cuomo had received a book contract to write about his experience during the pandemic provided more fodder for the cover-up narrative.

The intense focus of the press and elected officials was fueled, in part, by long-standing grievances with Gov. Cuomo. And the fall from grace was more precipitous because of the heights Gov. Cuomo's reputation had reached in the early months of the crisis.

Given the ongoing interest in this topic, it is likely that more facts will emerge over time and more sophisticated empirical analysis of the impact of the March 25 Advisory may, or may not, be conducted. I hope that this Commentary will add perspective on an issue that continues to create more heat than light.

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[3] "Commentary: New York needs an independent commission to review state's COVID response." Thomas P. DiNapoli. Albany Times Union. July 25, 2024. https://www.timesunion.com/opinion/article/n-y-needs-independent-commission-review-state-s-19591814.php
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[10] "Prolonged PCR positivity in elderly patients infected with SARS-CoV-2." Annaleise R. Howard-Jones, Susan Maddocks, Kerri Basile, Dominic E. Dwyer, James Branley, and Jen Kok. September 23, 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8457930/

[11] Over the course of the pandemic, it was only one of 480 State-issued policies and directives associated with the health and human services sector during the pandemic, of which 106 policies or directives were related to skilled nursing facilities, rehabilitation facilities, congregate care and long-term care facilities. See New York State Covid-19 After Action Report, prepared by the Olson Group, June 2024, at page 59: https://www.olsongroupltd.com/wp-content/uploads/2024/06/NYS-COVID-19-After-Action-Report-06142024-FINAL.pdf

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[18] "Walz: 'This was not a mistake' to discharge COVID-19 patients into home." Paul John Scott. Park Rapids Enterprise. May 27, 2020. https://www.parkrapidsenterprise.com/newsmd/walz-this-was-not-a-mistake-to-discharge-covid-19-patients-into-homes

[19] Dear Administrator Letter. New York State Department of Health. April 29, 2020. https://www.manatt.com/Manatt/media/Documents/Articles/NH-Letter-Regarding-Residents-4-29-20.PDF

[20] A Governor's Executive Order, 202.3, that was issued on May 10, 2020, and which was followed by a Dear Administrator Letter from DOH on May 11, 2020 – titled "ACF DAL #20-14, NH-20-07 Required COVID-19 Testing for all Nursing Home and Adult Care Facility Personnel" – included the requirement for a negative Covid-19 test prior to discharge from hospital to a nursing home.

[21] See p. 5: New York State Department of Health, "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis," July 6, 2020 (revised July 17, 2020, and February 11, 2021). Unfortunately, DOH has not made public more detailed information about the number of days from the initial infection of patients who were transferred from nursing homes, so we don't know the distribution of transfers below the median of nine days after hospital admissions.

[22] "Real-world study details average duration of infectiousness for COVID-19." Emily Head and Ryan O'Hare. Imperial College London. August 18, 2022. https://www.imperial.ac.uk/news/239213/realworld-study-details-average-duration-infectiousness/

[23] Ibid, p. 34.

[24] Ibid, p. 34.

[25] "Policy by Numbers." John Bacheller. https://policybynumbers.com/about-me

[26] The DOH Factors Report is discussed in some detail in the Assembly Impeachment Investigation Report that was prepared by the law firm Davis Polk based on extensive interviews with DOH and Executive Chamber personnel and reviews of documents.

[27] DOH Factors Report, p. 21.

[28] "Cuomo Aides Rewrote Nursing Home Report to Hide Higher Death Toll." J. David Goodman and Danny Hakim. The New York Times. https://www.nytimes.com/2021/03/04/nyregion/cuomo-nursing-home-deaths.html

[29] "COVID-positive Admissions Were Correlated with Higher Death Rates in New York Nursing Homes," by Bill Hammond and Ian Kingsbury, February 18, 2021, https://www.empirecenter.org/publications/covid-positive-admissions-higher-death-rates/

[30] Testimony of Bill Hammond, Senior Fellow for Health Policy, Empire Center for Public Policy, before the House Select Subcommittee on the Coronavirus Pandemic. May 17, 2023. https://docs.house.gov/meetings/VC/VC00/20230517/115959/HHRG-118-VC00-Wstate-HammondB-20230517.pdf

[31] Ibid.

[32] "Upstate" includes the 54 counties in New York other than the five boroughs of New York and Westchester, Nassau, and Suffolk.

[33] Hammond's analysis relies on three sets of data: (i) Covid-19 deaths in New York's long-term care facilities by date and location, released by DOH (publicly available); (ii) a database of coronavirus-positive admissions to nursing homes between March 25 and May 8 (released by DOH to the Associated Press and shared with the New York Post and the Empire Center, but which is not publicly available); and (iii) Nursing home census figures routinely posted by the Health Department on a weekly basis. Because the database of Covid-19 admissions to nursing homes between March 25 and May 8 is not public, we cannot replicate this analysis.

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[35] Information provided to the author by the Catholic Health System of Western New York.

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[40] Ibid.

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[46] "COVID-19 deaths in NY nursing homes were 50 percent higher than claimed: probe." Nolan Hicks, Bernadette Hogan, and Carl Campanile. The New York Post. January 18, 2021. https://nypost.com/2021/01/28/ny-nursing-home-covid-deaths-50-higher-than-stated-ag-probe/

[47] "US attorney's office in Brooklyn and FBI scrutinizing Cuomo administration's handling of data surrounding Covid nursing home deaths." Shimon Prokupecz and Paul LeBlanc. CNN. February 18, 2021. https://edition.cnn.com/2021/02/17/politics/us-attorneys-fbi-cuomo-covid-nursing-homes/index.html

[48] "Cuomo's national star threatened by increased scrutiny over handling of nursing home deaths." Gregory Kane. CNN. February 10, 2021. https://www.cnn.com/2021/02/20/politics/andrew-cuomo-nursing-home-controversy/index.html

[49] Impeachment Investigation Report, p. 5.

[50] Ibid, p. 4.

[51] Ibid, p. 40.

[52] Ibid, p. 40.

[53] "Use, Collection and Reporting of Infection Control Data." New York State Office of the State Comptroller. March 15, 2022. https://www.osc.ny.gov/state-agencies/audits/2022/03/15/use-collection-and-reporting-infection-control-data

[54] Ibid, p. 13.

[55] Ibid, p. 44.

[56] Ibid, p. 46.

[57] Ibid, p.54.

[58] Ibid, p. 54.

[59] As noted in this Commentary, there were temporary discrepancies in the first two months of the pandemic while newly developed data collection systems stabilized. Aside from these early technical issues, no one has disputed that the Cuomo administration fully included Covid-19 deaths in its total Covid-19 death figures.

Exhibit Q

Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis

New York State Department of Health

REVISED

February 11, 2021

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Executive Summary

In an effort to learn for the future from the data now available from the earliest days of the first in a century pandemic that swept across the globe and into the United States, the New York State Department of Health (NYSDOH) conducted an in-depth analysis of self-reported nursing home data that finds that COVID-19 fatalities in nursing homes were related to infected nursing home staff. The NYSDOH analysis found:

- The timing of staff infections correlates with the timing of peak nursing home resident mortality across the state;
- Nursing home employee infections were related to the most impacted regions in the state;
- Peak nursing home admissions occurred a week after peak nursing home mortality, therefore illustrating that nursing home admissions from hospitals were not a driver of nursing home infections or fatalities;
- Most patients admitted to nursing homes from hospitals were no longer contagious when admitted and therefore were not a source of infection; and,
- Nursing home quality was not a factor in nursing home fatalities.

According to data submitted by nursing homes, in many cases under the penalty of perjury, approximately 37,500 nursing home staff members—one in four of the state's approximately 158,000 nursing home workers—were infected with COVID-19 between March and early June 2020. Of the 37,500 nursing home staff infected, nearly 7,000 of them were working in facilities in the month of March; during the same period, more than a third of the state's nursing home facilities had residents ill with the virus. Roughly 20,000 infected nursing home workers were known to be COVID-positive by the end of the month of April. These workforce infections are reflective of the larger geographic impact of the virus's presence across the state.

NYSDOH further analyzed the timing of the COVID-positive staff infections and the timing of nursing home deaths. Based on published data, the average length of time between COVID-19 infections to death is between 18-25 days.[1] Therefore, the link between the timing of staff infection and nursing home mortality is supported by the fact that the peak number of nursing home staff reported COVID-19 symptoms on March 16, 2020—23 days prior to the date of the peak nursing home fatalities, which occurred on April 8, 2020. It is likely that thousands of employees who were infected in mid-March transmitted the virus unknowingly—through no fault of their own—while working, which then led to resident infection.

NYSDOH also examined the potential impact of the NYSDOH's March 25, 2020 admission policy. A survey conducted by NYSDOH shows that approximately 6,326 COVID-positive residents were admitted to facilities between March 25, 2020 and May 8, 2020; this finding is supported by an independent analysis done by the *Associated Press* on May 22, 2020.[2] However, an analysis of the timing of admissions versus fatalities shows that it could not be the driver of nursing home infections or fatalities. An individual nursing home-by-nursing home analysis of admissions versus fatalities further supports this finding.

A causal link between the admission policy and infections/fatalities would be supported through a direct link in timing between the two, meaning that if admission of patients into nursing homes caused infection—and by extension mortality— the time interval between the admission and mortality curves would be consistent with the expected interval between infection and death. However, the peak date COVID-positive residents entered nursing homes occurred

[1]Verity R, Okell LC, Dorigatti I, et al. Estimates of the severity of coronavirus disease 2019: a model-based estimate. *Lancet Infect Dis* 2020;20: 669–77. *See also* Flaxman S, Mishra S, Gandy A, et al. Report 13: Estimating the number of infections and the impact of non-pharmaceutical interventions on COVID-19 in 11 European countries. Imperial College London (30-03-2020).

[2] Condon, Bernard, Jennifer Peltz, and Jim Mustain, Over 4,500 virus patients sent to NY nursing homes, *Associated Press* (May 22, 2020) located at https://apnews.com/5ebc0ad45b73a899efa81f098330204c.

on April 14, 2020, a week *after* peak mortality in New York's nursing homes occurred on April 8, 2020. If admissions were driving fatalities, the order of the peak fatalities and peak admissions would have been reversed.

NYSDOH further analyzed the period of time patients stayed in hospitals prior to admission to nursing home facilities. Preliminary data show that residents were admitted to nursing homes a median of 9 days after hospital admission. Health experts believe that individuals infected with the virus are most infectious 2 days before symptoms appear and that they are likely no longer infectious 9 days after symptom onset – thus, by the time these patients were admitted to a nursing home after their hospital stay, they were no longer contagious.[3]

NYSDOH also considered the impact of visitation into nursing homes as a cause of infections. A review shows that prior to nursing home visitation being suspended completely on March 13, 2020, there was no tracking or testing of family and friends who were present in the facility, and any asymptomatic or symptomatic visitor could have been granted access. Given what we now know about how widespread the virus was in New York prior to testing availability in February and early March, there is a high likelihood that COVID-positive visitors entered nursing homes, although there is no specific data to support this assumption, and so ultimately this is inconclusive.

[3] Centers for Disease Control and Prevention, Symptom-Based Strategy to Discontinue Isolation for Persons with COVID-19, (Updated May 3, 2020) located at https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html.

Background[4]

Nations all across the globe have been significantly impacted by COVID-19. The situation rapidly and dramatically altered everyday life—requiring social distancing, closing of schools and businesses, and restricting access to hospitals and other congregate facilities.

New York State was one of the earliest states affected by COVID-19 resulting from inbound travel from Europe.[5] On March 1, 2020, NYS identified its first case of COVID-19 in an international traveler. On March 3, 2020, the first COVID-19 case with no travel-related risk factors was identified in Westchester, NY; contact tracing revealed additional infected contacts.

Congregate settings, like nursing homes, are particularly vulnerable to infectious diseases like COVID-19,[6] and many states and nations around the world have had to grapple with this difficult situation. The first known positive COVID-19 nursing home case in the United States was discovered when a Kirkland, Washington resident was transferred to a hospital on February 24, 2020 and later tested positive. In New York, the first introduction of COVID-19 into a nursing home known at the time occurred on March 5, 2020 when a nursing home staff member tested positive; the first confirmed case of COVID-19 in a nursing home resident known at the time occurred on March 11, 2020.

New York State has approximately 100,000 nursing home residents housed in 613 nursing home facilities statewide. Although an analysis conducted by the Kaiser Family Foundation in 2017 found that New York State has more nursing home residents than any state in the nation, despite being the fourth most populous state (Appendix A), New York's nursing

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4 The New York State Department of Health staff was supported by McKinsey & Company.

5 Gonzalez-Reiche AS, Hernandez MM, Sullivan M, et al, Introduction and Early Spread of SARS-CoV-2 in New York City, *Science* (May 29, 2020) doi: 10.1126/science.abc1917. Online ahead of print.

6 Centers for Disease Control and Prevention, Nursing Homes and Assisted Living (Long Term Care Facilities [LTCFs]), (June 26, 2020) retrieved from https://www.cdc.gov/longtermcare/index.html.

homes fatalities are not anomalous or disproportionate to the rest of the country. Data demonstrates that COVID-19 has been a challenge for nursing home facilities nationwide.

According to an analysis done by the *New York Times* on June 26, 2020, "at least 54,000 residents and workers have died from the coronavirus at these facilities for older adults in the United States, and as of June 26th, the virus has infected more than 282,000 people at some 12,000 facilities." The same *New York Times* analysis found that in terms of the percentage of total deaths in nursing homes, New York State ranked 46th in the nation—meaning 45 states had a greater percentage of fatalities (Appendix B).[7] Further, an examination of fatalities in our neighboring states—despite having populations much smaller than New York's—illustrates fatalities at these facilities were not a New York-specific phenomenon: Connecticut reports 3,124 deaths in these facilities, New Jersey reports 6,617, and Massachusetts reports 5,115, to New York's 6,432 fatalities. Looking at this on a per capita basis of nursing home deaths versus total population, Connecticut had 86 nursing home/long term care resident deaths for every 100,000 people, New Jersey 75 for every 100,000, Massachusetts 74 for every 100,000 people, Pennsylvania 35 for every 100,000 people, while New York had 33 for every 100,000 (Appendix C).

The New York State Department of Health (NYSDOH) undertook aggressive steps to prepare healthcare facilities for COVID-19 to prevent and control the spread of COVID-19 in the state's 613 nursing homes, issuing orders, directives and guidance to nursing homes on a variety of topics. For example, knowing personal protective equipment (PPE) would be critical and that there could be shortages because of global demand, on February 6, 2020 NYSDOH issued a

[7] 43% of U.S. Coronavirus Deaths Are Linked to Nursing Homes, *New York Times* (June 27, 2020) located at https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html?action=click&module=Spotlight&pgtype=Homepage. The *New York Times* uses nusing homes and long term care facilities in their analysis.

letter to all nursing homes stating, "The Department asks all facilities to compare their existing inventories of PPE, such as face shields, gowns, gloves, masks, N95 respirators, against the expected rate of use of these items under a surge situation, to determine the quantities needed to be on hand" and then to coordinate with existing vendors and local offices of emergency management to procure additional PPE.[8] Over the course of the crisis, New York State provided nursing homes with an unprecedented 8,510,729 pieces of PPE for their workers and others.

In addition to PPE, NYSDOH issued guidance: on infection control in healthcare facilities (February 25, 2020), specific nursing home infection control, and health and safety guidance (March 6, March 11, & March 13, 2020). On March 13, 2020 NYSDOH mandated staff temperature checks at the beginning of each shift, mandated use of face masks by all staff, and cancelled congregate activities within nursing homes. The same day, Governor Cuomo issued an executive order banning all nursing home visitation statewide, expanding an order issued days earlier in New York's first known 'hot spot' New Rochelle on March 7, 2020. Moreover, the state created strict penalties for non-compliance, including the potential for a nursing home to lose its operating license.

On May 10, 2020, New York State mandated twice-weekly testing of staff for nursing homes in regions of the state operating in phases I and II of reopening, and once-weekly testing for all nursing homes in phase III and beyond. NYSDOH surveyors and epidemiologists conducted over 2,000 calls, video assessments, and in-person assessments to support nursing homes and assess compliance with infection control and prevention practices and bring corrective action for any deficiencies through April 2020.

[8] Letter from NYSDOH Commissioner Howard A. Zucker to all nursing home operators (February 6, 2020).

Analysis of COVID-19 Nursing Home Fatalities

Below is an analysis of possible factors correlating to infection rates or mortality rates in nursing homes. We compared and analyzed the following nationwide data and factors—many of which have been suggested as potential causes of nursing home infections—to determine correlation, including:

I. COVID-19 staff illness in the nursing home as a possible source of exposure;

II. Potential transmission from residents with COVID-19 who were admitted to the nursing homes;

III. Nursing home quality of care ratings contributing to COVID-19 resident exposures; and,

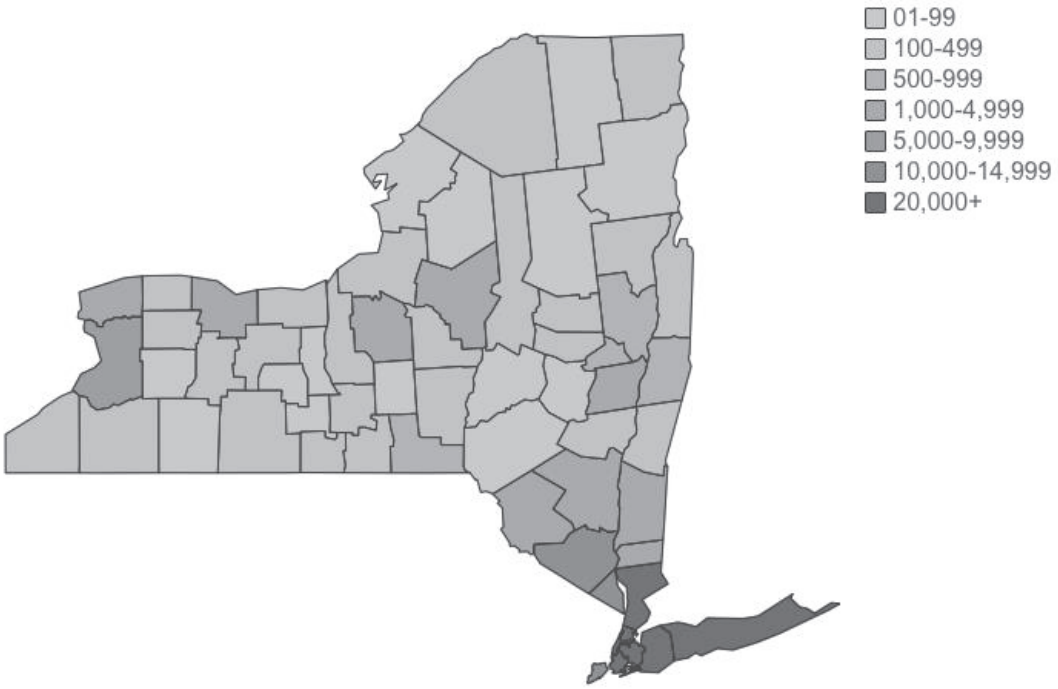
IV. The age of the nursing home residents as a factor for mortality.

I. COVID-19 Staff Illness Contributed to Infections of Nursing Home Residents

Since New York State's first confirmed COVID-19 case on March 1, 2020, until July 5, 2020, New York State has tested 4,233,803 people with 397,131 testing positive.[9] Within New York State, there has been significant geographic variation in overall positive tests by region (Figure 1) and within nursing home cases and fatalities. The most impacted regions in New York State were in the downstate region (Mid-Hudson Valley, New York City, and Long Island) —those regions had the highest nursing home fatality rates.

[9] See New York State Department of Health COVID Tracker at https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Map?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n.

Figure 1. **Persons Testing Positive for COVID-19 by County, July 5, 2020**



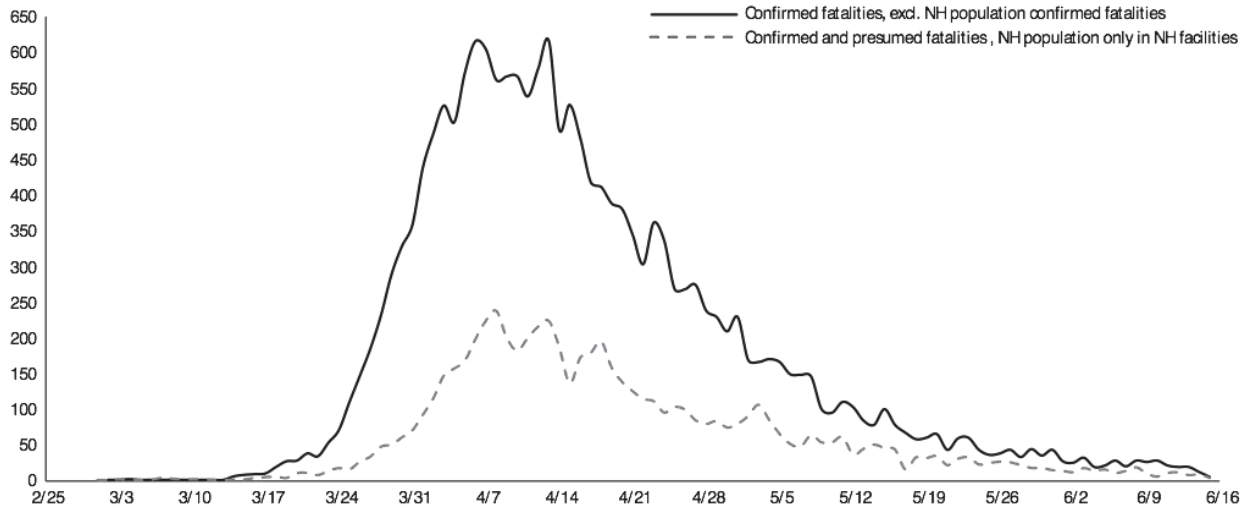
SOURCE: New York State COVID Tracker, located at https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Map?%3Aembed=yes&%3Atoolbar=no&*%3Atabs=n,* Accessed June 28, 2020.

As Figure 2 demonstrates[10], the mortality curve for nursing home residents closely follows the mortality curve for non-nursing home residents, with the peaks occurring at similar dates. As Figure 2 also illustrates, the peak was in early April suggesting the virus was spreading in many instances much earlier than first thought. An independent antibody study found that early infections—virtually undetected—were happening much earlier than initially thought in February of 2020.[11] This suggests a correlation between infections in geographical broader public infections and infections in nursing homes. Many of the nursing home residents were in those areas most impacted in New York State, including in the outer boroughs of New York

[10] This trend with a similar 3 city survey found in a recent article in the Journal of the American Medical Association. *See:* Michael L. Barnett, Hu, Lissy, et al, Mortality, Admissions, and Patient Census at SNFs in 3 US Cities During the COVID-19 Pandemic, JAMA. Published online (June 24, 2020), doi:10.1001/jama.2020.11642.
[11] Mandavilli, Apoorva, In Early February, the Coronavirus Was Moving Through New York, *New York Times* (June 30, 2020) located at https://www.nytimes.com/2020/06/30/health/coronavirus-ny.html.

City, Long Island, and the Mid-Hudson Valley. For example, 80% of all infected nursing home staff were from the most impacted areas of the state: New York City (48%), Long Island (17%), and the Mid-Hudson Valley (15%) with only 20% coming from the rest of the state. Not only was the number of nursing home staff significant, they were found in the most impacted regions, correlating to the overall infections in the most impacted regions.

Figure 2: **Comparison of Non-Nursing Home and Nursing Homes COVID-19 Fatalities Over Time**

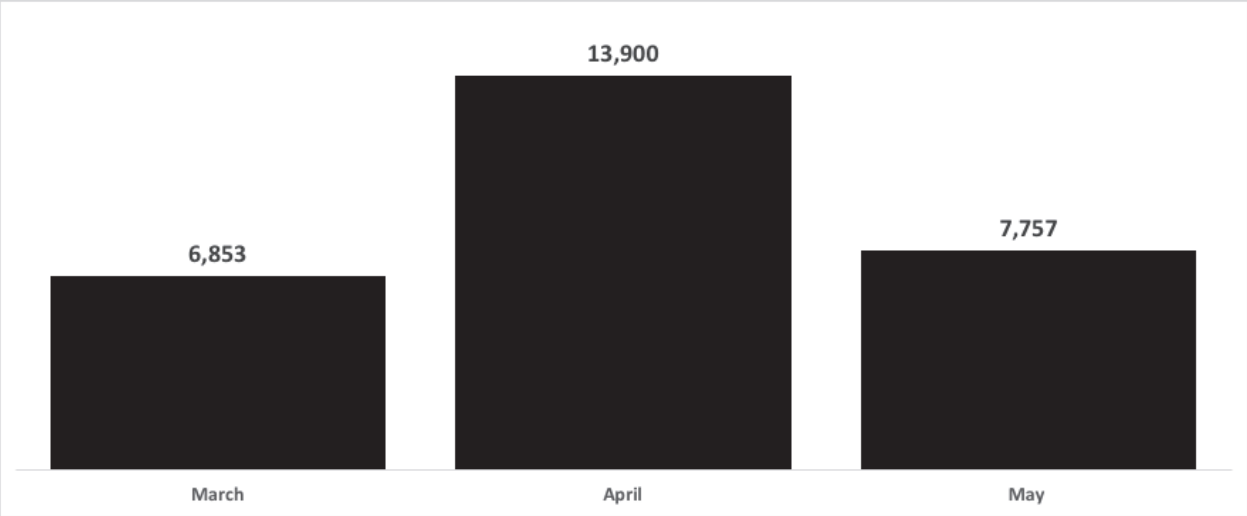


SOURCE: NYSDOH Daily Health Emergency Response Data System (HERDS) as of June 16, 2020.

Evidence suggests that nursing home residents were infected with COVID-19 as a result of transmission by the workforce. Based on a NYSDOH nursing home supplemental survey conducted on June 9, 2020 for the months of March, April, and May, 28,510 nursing home staff were confirmed or suspected COVID-positive cases across New York State.

Between May 20, 2020 and June 16, 2020, following Governor Cuomo's Executive Order mandating twice-weekly staff testing resulted in approximately 9,000 staff tested positive. That means that out of approximately 158,000 nursing home employees in the state, approximately 37,500 nursing home staff were presumed or confirmed positive for COVID-19—or one out of every four workers were infected.

Figure 3. Number of Nursing Home Employees Confirmed or Suspected To Be COVID-Positive, March 2020-May 2020



SOURCE: NYSDOH Nursing Home Staff Testing Survey, June 8, 2020, data reported by NYS nursing homes to NYSDOH.

Additional studies support this finding and suggest the number of staff infections could have been even higher. A May 2020 serological study conducted by the lab BioReference of roughly 3,500 nursing home employees in New York State found that 29% of the nursing home staff tested positive for having the COVID-19 antibodies.[12] Extrapolating that number, up to 45,820 nursing home staff were infected by May—or nearly one in three workers.

Why were infected nursing home staff able to likely infect residents in the nursing homes? In March, the federal government's Centers for Disease Control and Prevention (CDC) did not suspect that asymptomatic people were likely to spread the infection. First, there was no CDC recommendation for testing nursing home staff until recently, and the CDC guidance issued during February, March, and April varied in its recommendations, or lack of recommendations,

[12] BioReference Laboratories, Inc, Health's BioReference Laboratories Reports Results of COVID-19 Testing for Almost One Quarter of a Million Nursing Home and Live-in Facility Employees, (July 1, 2020) located at https://www.prnewswire.com/news-releases/opko-healths-bioreference-laboratories-reports-results-of-covid-19-testing-for-almost-one-quarter-of-a-million-nursing-home-and-live-in-facility-employees-301086786.html.

for when asymptomatic recovering or exposed healthcare workers could work, a reflection of the evolving understanding of the risk these people posed.

Moreover, CDC also issued guidance on March 7, 2020 that stated certain asymptomatic healthcare personnel exposed to others with the virus were "not restricted from work."[13] This early, and ultimately erroneous, understanding of viral spread allowed many nursing home COVID-positive employees to continue working. It was not until much later, as the true number of asymptomatic cases became clear, that evidence based upon contact tracing established definitively that asymptomatic people were in fact capable of spreading the virus.

To compound the situation, on March 16th the CDC issued guidance that nursing home employees who were symptomatic, but not tested, should wait only three days after the symptoms had passed to return to work and only seven days after the COVID-19-like symptoms first appeared.[14] As more was learned about COVID-19, CDC issued updated guidance on April 13th for asymptomatic workers and April 30th for symptomatic workers by increasing isolation to 10 days.[15] However, by that point, as data show, the disease was already at its peak in the

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[13] Centers for Disease Control and Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19), (March 7, 2020). CDC did not recommend changing the beginning of the exposure period from the onset of symptoms to "48 hours before symptom onset" until April 2020.

[14] Centers for Disease Control and Prevention. Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance), (March 16, 2020) retrieved from https://web.archive.org/web/20200404023742/https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html.CDC issued guidance regarding return to work for health care personnel but did not address asymptomatic COVID-19 positive healthcare personnel. Therefore, on March 31st, NYSDOH guidance issued to address this by applying the non-test based strategy to these individuals to exclude them for at least 7 days after the positive test result. *See* Updated Protocols for Personnel in Healthcare and Other Direct Care Settings to Return to Work Following COVID-19 Exposure or Infection (March 31st, 2020). This directive has since been superseded.

[15] Centers for Disease Control and Prevention, Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19, (April 13, 2020) retrieved from https://web.archive.org/web/20200417211515/https:/www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html; CDC, Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance) (April 30, 2020) located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html.

nursing homes (Figure 2). It is likely that a significant percentage of both mildly symptomatic and asymptomatic employees were advised to continue working during March and April and thus unknowingly spread the disease within the facility. The entire situation was further compounded by the lack of testing nationwide capacity in March, making it impossible to have an accurate assessment of which nursing home staff were COVID positive.

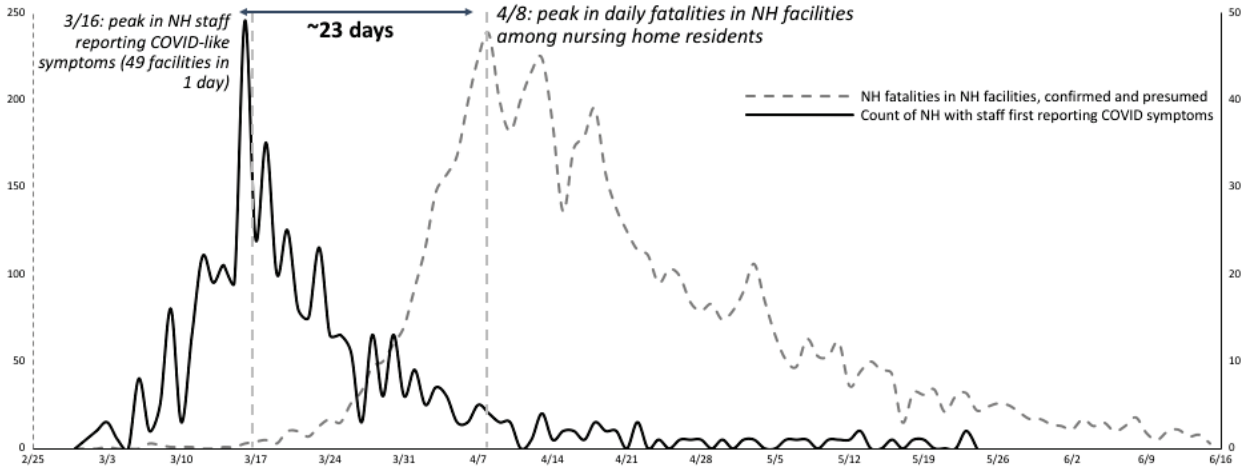
As Figure 4 illustrates below, the peak of nursing home fatalities was in early April. In order to address possible correlation, you must consider COVID-19's incubation period. According to the CDC,[16] the incubation period for COVID-19 is as follows:

- Infection to symptoms: Avg. 5 days (range 2-14)
- Symptoms to hospital: Avg. 8 – 12 days
- Infection to hospital: Avg. 13 – 17 days
- Symptoms to death: Avg. 13 – 20 days
- Infection to death: Avg. 18 – 25 days

Given this incubation period, it is likely that thousands of employees infected in mid-March could have unknowingly—through no fault of their own— transmitted the virus while working, which then led to resident infection, something that Figure 4 demonstrates. The average length of time between infections to death is between 18-25 days. Therefore, an analysis of the timing between known nursing home staff infections and nursing home fatalities indicates that they are correlated due to the fact that the peak number of nursing home staff reporting COVID-19 symptoms occurred 23 days prior to the date of the peak nursing home fatalities.

[16] Centers for Disease Control and Prevention, Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19), (Updated May 29, 2020) located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

Figure 4. Number of Nursing Homes Reporting First Symptomatic Staff and Nursing Home Resident Fatalities Timeline



SOURCES: NYSDOH Nursing Home Staff Testing Survey, June 8, 2020, data reported by NYS nursing homes to NYSDOH and NYSDOH Daily Health Emergency Response Data System (HERDS) survey.

However, other factors that cannot be ruled out include spread from family and visitors. As Figure 4 illustrates, nursing home fatalities were increasing in mid-March. New York State acted early in its outbreak to ban any non-medical visitation, including family and friends, on March 13, 2020. The nursing home fatality peak was April 8, 2020. Given this timing, and given the COVID-19 incubation period, it is possible that with visitation by family and friends prior to March 13th, the potential for positive COVID-19 cases being among those visitors and spreading it within the facility was a contributing factor. There is no data on the infection rate of nursing home visitors, so this is inconclusive. All of this activity well pre-dated the March 25 admission policy for COVID-positive residents (*Infra*).

II. Potential Transmission from Residents with COVID-19 Who Were Admitted to the Nursing Homes

One of the factors that has been suggested by some observers to contribute to nursing home infections and subsequent fatalities is that the admission of COVID-positive residents introduced COVID into nursing homes. However, data does not support this assertion.

If the March 25th NYSDOH policy on admissions uniquely impacted nursing home fatalities, New York's—and the roughly 12 other states with similar policies—nursing home fatalities would be disproportionate to the rest of the country. Not only has a recent report by the *New York Times,* found that New York's nursing home fatalities were not disproportionate to the rest of the nation (*See,* Background, *Infra.*), neighboring states—despite having populations much lower than New York's—illustrates that on a per capita basis, New York has one of the lowest fatality rates in nursing homes of any of its neighboring states (Appendix C).

New York State followed the federal government's Centers for Medicare & Medicaid Services (CMS) guidance which stated that nursing homes should accept residents with COVID-19 as long as they can use transmission-based precautions.[17] The federal guidance specifically states, "Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present."[18]

NYSDOH's March 25, 2020 admission guidance stated, "No resident shall be denied re-admission or admission to the NH *solely* based on a confirmed or suspected diagnosis of

[17] U.S. Centers for Medicare and Medicaid Services, Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (Revised) (Report Ref: QSO-20-14-NH), (March 13, 2020), Baltimore MD: US Centers for Medicare and Medicaid Services.
[18] Id at page 5.

COVID-19" (*emphasis added).*[19] However, contrary to some press reports, neither CMS guidance nor the state ever *directed* that a nursing home must accept a COVID-positive person. In fact, the opposite is true. By state law, a nursing home could *not* accept a COVID-positive person unless the nursing home could provide adequate care. Title 10 of New York State Codes, Rules and Regulations clearly states a nursing home, "shall accept and retain only those nursing home residents for whom it can provide adequate care."[20] It was in the nursing homes' sole discretion to determine if they would accept the COVID-positive person and if they could provide adequate care. Thus, it would be against the law for any nursing home operating in New York State to accept a patient it could not care for—in this instance that specifically meant a nursing home's ability to properly isolate patients and follow protective procedures.

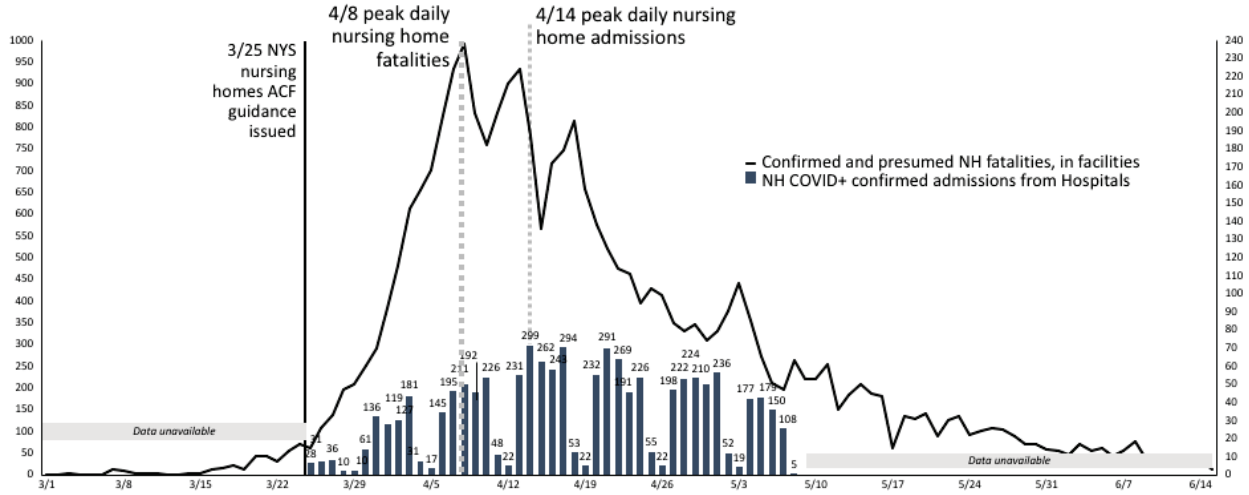
Admission of COVID-19 Patients

(Revised July 17, 2020 --- See Addendum page 34)

A statewide nursing home survey conducted by NYSDOH for admission data from March 25, 2020- May 8, 2020 show that approximately 6,326 COVID-19 patients were admitted from a hospital to a total of 310 unique nursing homes. Of the 310 nursing homes that admitted COVID-19 patients, 252 of them already had a suspected or confirmed COVID-positive resident, COVID-related confirmed or presumed fatality, or worker infected prior to admission of a single COVID-positive patient—meaning the admission of a COVID patient *did not* introduce COVID into the nursing home as it was already present. Furthermore, 222 of the state's nursing homes already had residents with confirmed or suspected COVID-19 prior to the March 25, 2020 NYSDOH guidance.

[19] NYSDOH, Advisory: Hospital Discharges and Admissions to Nursing Homes (March 25, 2020).
[20] See Title 10 of the New York State Code of Rules and Regulations, section 415.26, (ii).

Figure 5. **Nursing Home Fatality Curve and Admissions Over Time**

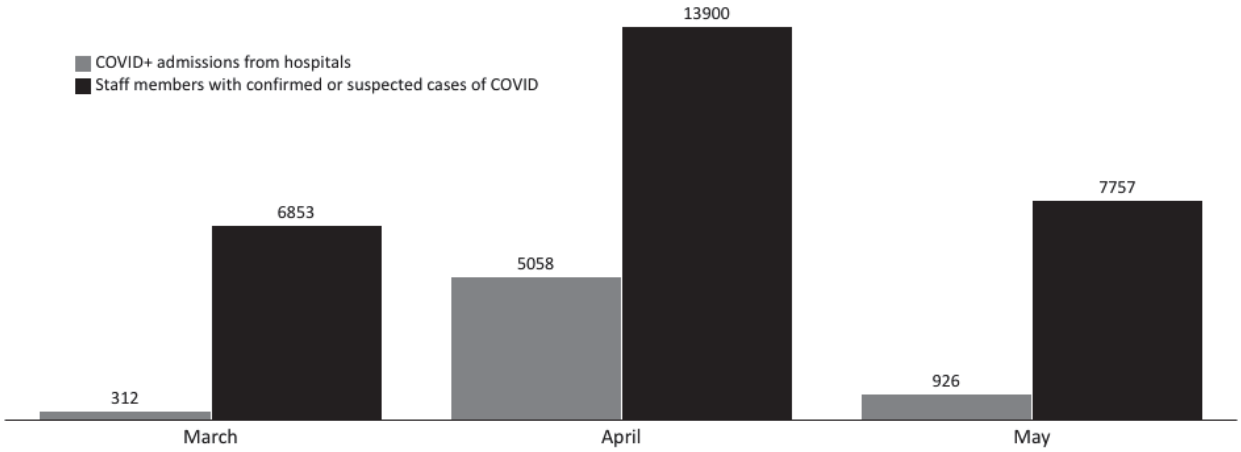


SOURCE: NYSDOH Facility Survey as of May 27, 2020 for COVID Positive Admissions from March 1, 2020 - May 8, 2020.

Figure 5 above shows the timeline of nursing home resident fatalities and COVID-19 admissions. Nursing home resident fatalities peaked on April 8, 2020. The peak of nursing home admissions from hospitals did not occur until April 14, 2020, a week *after* peak nursing home fatalities—suggesting the policy was not the cause.

Further, as Figure 5 shows, admissions of residents with COVID-19 were still increasing when the number of nursing home deaths was already *declining*. If the March 25, 2020 guidance was the major cause of exposures leading to nursing home deaths, the time interval between the admission and mortality curves would be consistent with the expected interval between infection and death. Figure 6 shows a comparison of the number of COVID positive admissions versus known COVID staff infections by month.

Figure 6. Comparison between Infected Nursing Home Employees and Resident Admissions



SOURCE: NYSDOH facility survey March 25, 2020 to May 8, 2020 Admissions and DOH Facility Staff Illness Survey.

In addition, the data suggests that people admitted from hospitals to nursing homes were most likely not contagious. Per CDC data, COVID-positive individuals are likely not capable of transmitting the virus after 9 days from the onset of the illness. The CDC stated, "The statistically estimated likelihood of recovering replication-competent virus approaches zero by 10 days."[21] This comports with the CDC policies related to return to work and removal from isolation precautions after a positive COVID test. CDC isolation period has been currently established to be 10 days. In April, the CDC suggested an even more reduced isolation period of 7 days after testing positive as long as 72 hours had been with symptoms reducing and no fever.[22] After this date, infected persons are unlikely to transmit the virus, although it may still

[21] Centers for Disease Control and Prevention, Symptom-Based Strategy to Discontinue Isolation for Persons with COVID-19, (Updated May 3, 2020) located at https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html.

[22] Centers for Disease Control and Prevention, Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19, (Updated April 13, 2020) retrieved from https://web.archive.org/web/20200417211515/https:/www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html.

result in a positive PCR test. Length of stay data shows that for nursing home admissions, the length of hospital stay was a median of 9 days. This is likely beyond the period of viral transmission. According to researchers and health experts, individuals with COVID-19 are most infectious 2 days before symptoms appear and likely no longer infectious 9 days after symptom onset.[2324]

COVID Readmissions[25]

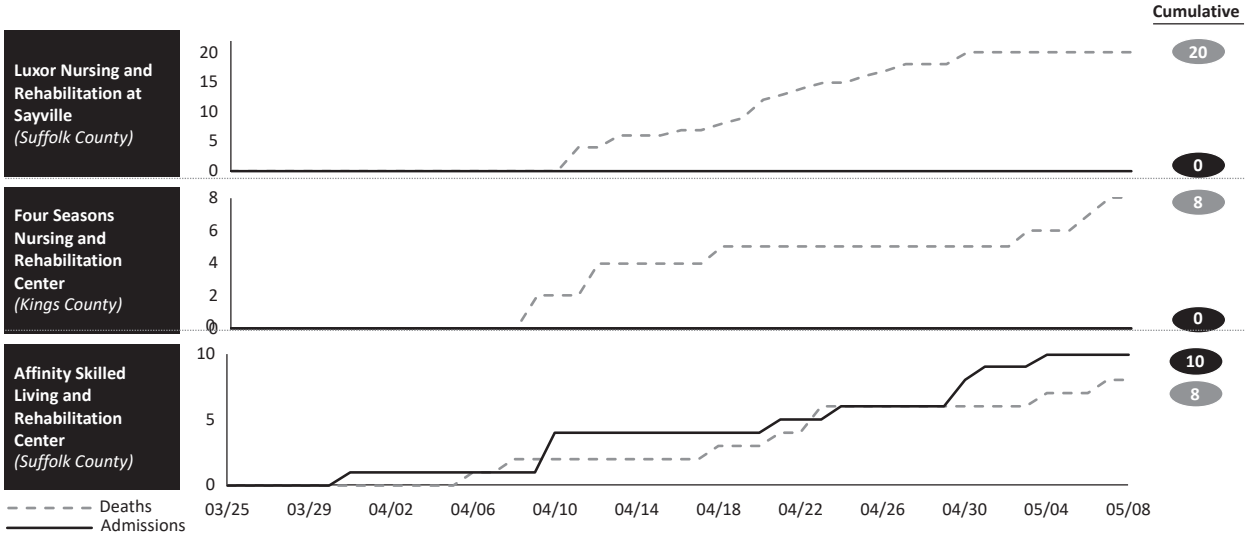
Readmissions into nursing homes are patients who went to the hospital *from* a nursing home, were treated and returned back to their nursing home. By definition these patients could not have been responsible for introducing COVID into their nursing home, as they had COVID prior to going to the hospital for treatment and before being readmitted. These residents were pre-symptomatic or in the early stages of illness at the nursing home when they would have been infectious but before COVID-19 might have been recognized and the resident put on transmission-based precautions. Therefore, based on the most cautious current provisions, most patients readmitted to nursing homes were likely not infectious, for the time they were being readmitted would have far exceeded the CDC standard.

[23] Zou L, Ruan F, Huang M, et al. SARS-CoV-2 Viral Load in Upper Respiratory Specimens of Infected Patients. *N Engl J Med* 2020;382:1177-9.
[24] He, X., Lau, E.H.Y., Wu, P. et al. Temporal dynamics in viral shedding and transmissibility of COVID-19. *Nat Med* 26, 672–675 (2020).
[25] Title and first sentence typos corrected.

Did Admissions Increase Mortality?

The data do not show a consistent relationship between admissions and increased mortality. As exemplified in Figure 7, there were cases where nursing homes did not admit any COVID-positive patients, yet still had a high number of COVID-related deaths. As the chart demonstrates, one facility with zero admissions or admissions still had 20 deaths and another had zero admissions, yet 8 deaths. In fact, 132 nursing homes that had zero admissions from hospitals nonetheless had one or more COVID-19 fatalities. A total of 97 facilities had their first COVID-19 fatality before or on the day of their first admission.

Figure 7. Cumulative Mortality Versus Admissions, Select Facilities

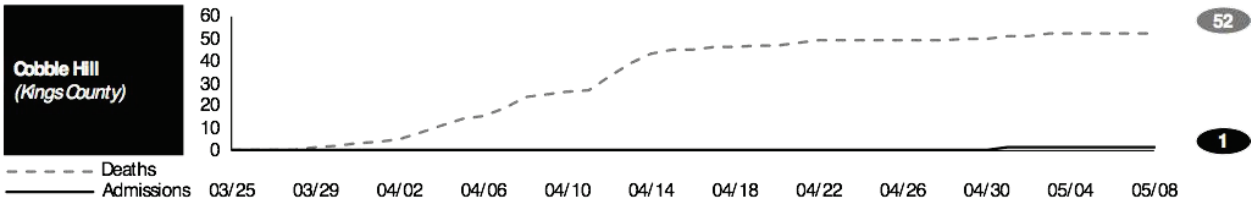


SOURCE: NYSDOH Facility Survey as of May 27, 2020 for Admissions from March 1, 2020 - May 8, 2020.

In addition, some nursing-home specific cases also demonstrate that admissions policies were not the determinative factor. For example, virtually all of the Cobble Hill Health Facility's fatalities happened by April 14, 2020 (43 of the 52); yet Cobble Hill Health Facility had only one COVID-positive admission and it did not occur until April 30, 2020. Thus, the admission of

COVID-positive patients was not a factor in the Cobble Hill Health Facility nursing home fatalities.

Figure 8. Cumulative Mortality Versus Admissions, Cobble Hill Health Center



SOURCE: NYSDOH Facility Survey as of May 27, 2020 for Admissions from March 1, 2020 - May 8, 2020.

Did Patients Coming from Hospitals Have Alternatives to Nursing Homes?

There was no need for nursing homes to accept COVID-positive patients if they could not provide adequate care in a safe environment, as required by state law, as there were alternatives available facilities for such patients. New York State had secured various alternative facilities, with a significant number of beds suitable for COVID-positive nursing home patients, had any nursing home declined to accept a COVID-positive patient. During the outbreak, the State even created COVID-positive exclusive facilities for nursing home residents across the state. In New York City, the State created the Brooklyn Center in Brooklyn with 281 beds run by Maimonides and South Beach in Staten Island with 259 beds operational. Upstate, Catholic Health's St. Joseph Post-Acute Center (operating under the license of Father Baker Manor Home) was made a COVID-only facility with 80 beds. In addition, surplus capacity was made available at SUNY Downstate Hospital in Brooklyn and SUNY Upstate Hospital in Syracuse. Therefore, there was no need for nursing homes to accept COVID-positive patients <u>if</u> they did not believe they could provide adequate care, as required by law, as the State had available alternatives. The State

Department of Health and Attorney General's office are doing an investigation to determine, among other things, if nursing homes violated this law.

Further, questions have been raised by the *New York Times* about the potential profit motivation by some nursing homes to evict certain low-income patients to be able to accept COVID-positive patients as the reimbursement for treatment is higher than that for traditional Medicaid patients.[26] The NYSDOH has begun to investigate these claims.

III. Nursing Home Quality Contributing to COVID-19 Resident Exposure

We analyzed whether nursing homes that had a lower quality rating over the past several years had a higher death rate than nursing homes with a record of higher star ratings. In fact, this hypothesis is not substantiated. Using the quality rating system developed by CMS, 5-Star Quality Rating System, nursing homes with higher CMS quality ratings were found to have higher mortality rates than those with lower quality ratings. The mortality rate was higher in 5-star rated facilities (i.e. better rated) than it was in the lowest-rated facilities (12% mortality rate in 5-star, versus 7% in the lowest rated).[27]

From the data, the apparent explanation for this phenomenon is that the geographic location of the nursing home facility, and its corresponding rate of community infection, had a greater connection than the performance of the nursing home facility. Data show the

[26] Jessica Silver-Greenberg and Amy Julia Harris, "'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents" *New York Times* (June 21, 2020) located at https://www.nytimes.com/2020/06/21/business/nursing-homes-evictions-discharges-coronavirus.html.

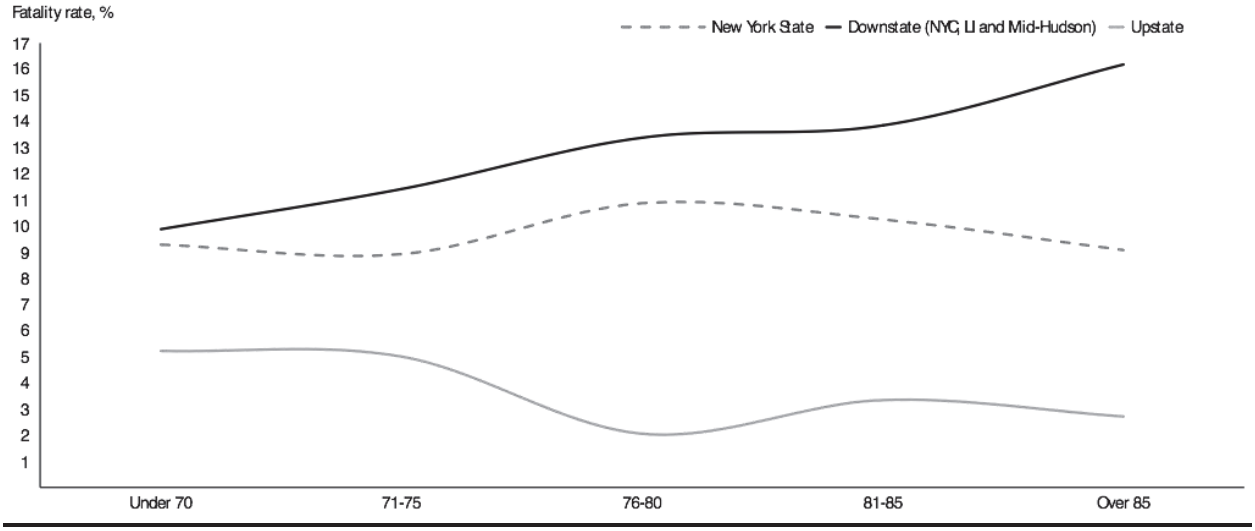
[27] NYSDOH Facility Survey as of May 27, 2020 for Admissions from March 1, 2020 - May 8, 2020, Nursing Homes detail as of May 26, 2020. Facility ratings come from https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py.

predominance of nursing home deaths were in downstate New York and unrelated to the performance of the particular nursing home.

IV. Age of the Nursing Home Resident as a Factor for Mortality

Another factor was reviewed in relation to nursing home fatalities—age of the resident. As data show, older individuals are more susceptible to death from COVID-19 infection.[28] The analysis between resident age and mortality suggests a relationship between a higher median resident age and an increase in the mortality rate in downstate New York; this trend was not evident in the rest of New York where there were fewer nursing homes deaths.

Figure 9. Age Versus Nursing Home Fatality Rate by Region



SOURCE: MDS Q4 2019 - Analysis of age of the residents in the nursing homes

[28] CDC COVID-19 Response Team. Severe outcomes among patients with coronavirus disease 2019 (COVID-19)—United States, February 12–March 16, 2020. MMWR Morb Mortal Wkly Rep 2020;69:343–6.

Conclusion

When examining the data, several factors are clear from our analysis and research:

- Data suggest nursing home quality is not a factor in mortality from COVID.
- Admission policies were not a significant factor in nursing home fatalities.
- Employee infections were related to the larger community spread and employee transmission has the strongest correlation to nursing home fatalities.

Comparing nursing home policies and mortality rate timelines suggests COVID-19 transmission is strongly correlated to nursing home employees entering the facility. Early in the COVID-19 pandemic, the consensus among public health experts suggested asymptomatic people did not spread the disease and asymptomatic positive or presumed positive employees were allowed to continue to work. Later in the crisis, public health experts were forced to reverse this position as it became clear from the data that asymptomatic people could transmit the disease.

In addition, independent testing done by BioReference in May showed 29% of nursing home employees surveyed had COVID antibodies. Extrapolating the data means that approximately one in three nursing home workers were infected. Such a high percentage of employees having at one time been positive for COVID-19 suggests a strong correlation to contributing to the spread to patients.

Our analysis brings to the forefront the possibility of transmission from staff as an important mode of transmission. If states had accurate information about COVID transmission at an earlier time and had the testing capacity to detect asymptomatic but infected individuals, other procedures might have been taken. For example, all asymptomatic employees should have been barred from facilities as if they were symptomatic, which is the current policy (*See,* Directive April 29, 2020 to Nursing Home Administrators). If widespread testing was available

earlier, all employees could have been tested earlier (*See,* Executive Order 202.30, as amended). These are national issues that must be addressed (e.g. better training of staff, enhanced and rapid testing, and better coordination with other healthcare facilities) as nursing homes and other congregate settings will pose a continued risk for the Coronavirus or another public health threat in the future that attacks older adults.

Appendices

Appendix A. Nursing Home Facilities, by State

State	Number of Nursing Facilities	Number of Residents
Alabama	228	22,482
Alaska	18	608
Arizona	145	11,343
Arkansas	231	17,439
California	1,198	101,030
Colorado	221	16,078
Connecticut	223	22,653
Delaware	45	4,181
District of Columbia	18	2,380
Florida	690	72,741
Georgia	359	33,043
Hawaii	42	3,474
Idaho	71	3,319
Illinois	731	66,643
Indiana	552	38,682
Iowa	437	23,638
Kansas	276	14,657
Kentucky	285	22,760
Louisiana	277	26,169
Maine	100	5,947
Maryland	226	24,414
Massachusetts	399	38,673
Michigan	443	38,062
Minnesota	375	24,755

Mississippi	204	15,950
Missouri	518	37,874
Montana	72	4,153
Nebraska	214	11,394
Nevada	61	5,336
New Hampshire	74	6,442
New Jersey	364	44,033
New Mexico	74	5,693
New York	613	101,518
North Carolina	429	35,763
North Dakota	80	5,531
Ohio	966	73,826
Oklahoma	303	18,361
Oregon	136	7,317
Pennsylvania	693	76,652
Rhode Island	83	7,817
South Carolina	191	16,993
South Dakota	108	5,984
Tennessee	314	26,481
Texas	1,227	92,250
Utah	99	5,178
Vermont	36	2,440
Virginia	286	27,595
Washington	217	15,993
West Virginia	123	9,251

Wisconsin	374	24,239
Wyoming	38	2,428
TOTAL USA	15,483	1,321,663

SOURCE: KFF, Total Number of Residents in Certified Nursing Facilities (2017) located at https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Appendix B. Cases and Deaths in Nursing Homes, by State

		Facilities	Cases	Deaths	Share of COVID Deaths
	United States	12,000	282,000	54,000	43%
1	New Hampshire	26	1,967	293	80%
2	Rhode Island	64	2,745	715	77%
3	Minnesota	853	5,777	1,107	77%
4	Connecticut	289	9,888	3,124	73%
5	Pennsylvania	678	20,689	4,518	68%
6	North Dakota	65	569	56	64%
7	Massachusetts	565	23,321	5,115	64%
8	Idaho	30	323	56	62%
9	Maryland	289	12,641	1,924	61%
10	Virginia	236	6,714	1,039	61%
11	Kentucky	172	2,626	350	61%
12	Washington	389	4,376	779	60%
13	Vermont	6	172	32	57%
14	Ohio	530	9,928	1,580	57%
15	North Carolina	170	5,445	746	57%
16	Maine	16	485	58	56%
17	Kansas	100	927	149	56%
18	Oregon	49	821	112	55%
19	Colorado	166	5,660	910	54%
20	Oklahoma	134	1,647	201	53%
21	Florida	1,011	11,472	1,748	52%
22	Delaware	31	687	263	52%
23	Illinois	593	21,390	3,649	52%
24	Iowa	54	2,030	360	51%
25	Mississippi	137	2,787	507	50%
26	West Virginia	37	394	45	49%
27	California	923	23,646	2,832	48%

28	South Carolina	171	2,541	317	46%
29	Georgia	533	9,939	1,237	45%
30	New Jersey	562	36,316	6,617	44%
31	Indiana	268	5,147	1,140	44%
32	Texas	863	6,641	1,031	44%
33	South Dakota	58	384	38	43%
34	Utah	191	906	70	42%
35	Louisiana	400	7,833	1,315	41%
36	New Mexico	55	250	180	37%
37	Arizona	289	3,902	541	—
38	Tennessee	85	1,513	195	34%
39	Nebraska	119	519	92	34%
40	Arkansas	113	978	83	33%
41	Michigan	240	10,630	2,031	33%
42	Montana	3	35	7	32%
43	District of Columbia	20	1,072	173	32%
44	Wyoming	4	54	6	30%
45	Nevada	75	1,289	135	27%
46	New York	509	7,177	6,432	21%
47	Alabama	131	3,746	112	—
48	Hawaii	15	89	1	—
49	Missouri	118	1,394	15	—
50	Alaska	10	93	0	—
51	Wisconsin	318	1,242	0	—

SOURCE: *New York Times;* States with insufficient data to calculate a share of Covid-19 deaths are shaded gray. The *New York Times* analysis included long term care facilities.

Appendix C. Nursing Home Fatalities as a Percentage of Nursing Home Residents and General Population

State	# of Deaths	Total Nursing Home Residents	Total Nursing Home Facilities	Deaths Per Capita to Total State Population (per 100k people)
CT	3,124	21,335	213	86
MA	5,115	41,000	476	74
NJ	6,617	61,000	615	75
PA	4,518	20,689	678	35
NY	6,432	101,518	613	33

SOURCE: NYSDOH Analysis of KFF data (Table 1) and *New York Times* (Table 2). The *New York Times* analysis included long term care facilities.

Addendum to Page 17

Admission of COVID-19 Patients

The New York State Department of Health (NYSDOH) continuously receives data from testing sites, laboratories, hospitals, nursing homes and other sources as part of its aggressive response to the novel coronavirus pandemic. These data are incorporated into ongoing analyses to better understand the pandemic and inform future efforts. This allows us to provide an update to page 17 of the "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis" report.

A statewide nursing home survey conducted by NYSDOH for admission data from March 25, 2020 - May 8, 2020 shows that approximately 6,326 COVID-19 patients were admitted from a hospital to a total of 310 unique nursing homes. The initial analysis examined whether COVID infection was present in a nursing home prior to March 25th. To better measure any impact of the policy, this analysis examines whether COVID infection was present in a nursing home prior to that nursing home's first COVID admission from a hospital because a facility's first admissions may have happened over the entire period, including after March 25th.

The new analysis shows that 304 of the 310 nursing homes—or 98 percent— already had a suspected or confirmed COVID-positive resident, COVID-related confirmed or presumed fatality, or worker infected prior to admission of a single COVID-positive patient. Again, this means that for 98 percent of the facilities, the admission did not introduce COVID-19 into the nursing home because it was already present. Of the 6 nursing homes that admitted a patient before there was a COVID infection of staff or residents, or fatality in that facility:

- One facility's admission came on the same day as the presumed or confirmed infection or fatality (Charles T. Sitrin Health Care Center);
- One facility's admission came a day before the presumed or confirmed infection or fatality (Newfane Rehabilitation and Health Care Center);
- One facility's admission came two days prior to the presumed or confirmed infection or fatality (Rego Park Nursing Home);
- One facility's admission came six days prior to the presumed or confirmed infection or fatality (Gowanda Rehabilitation and Nursing Center);
- One facility's admission came 13 days prior to the presumed or confirmed infection or fatality (The Grand Rehabilitation and Nursing at Barnwell); and,
- One facility's admission came 22 days prior to the presumed or confirmed infection or fatality (Presbyterian Home for Central New York).

Therefore, given the timing, in all but two cases, it is highly unlikely that the admission caused the infection or fatality. This updated analysis does not change the findings of the report; in fact, it more strongly reaffirms the initial findings.

Addendum

Post-Audit Addendum

Since the report "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis", (the "Report") was issued, NYSDOH has completed additional analyses of relevant data specific to where fatalities of nursing home residents occurred.

NYS DOH undertook an extensive audit of fatality reports submitted by nursing homes to ensure the numbers presented to the public were accurate. This activity included removing duplicative and erroneous entries in the data reported directly by nursing homes to NYSDOH in daily surveys and matching records across data systems that do not share unique identifiers. As fatalities were verified or found to be erroneous or duplicative, the data was added and removed from the public facing website accordingly. This process also allowed NYSDOH to identify and update the number of fatalities of nursing home residents believed to have occurred outside of the nursing home, such as in a hospital.

Using reconciled data, NYSDOH reanalyzed the entire data set, including out of-facility nursing home deaths, to assess the impact of the audit on previous analysis results and conclusions. The results of the rerun analyses of the fuller data set did not yield any findings that would alter the conclusions of the Report. In fact, when considering the entire data set and new information since the Report's issuance, the Report's conclusions are reconfirmed.

- The date of the peak number of nursing home deaths did not change and remains April 8 when including out of facility fatalities (Updated Figure 2 – See below).
- The timing of staff infection and peak nursing home resident mortality remains unchanged when including out of facility fatalities (Updated Figure 4 – See below).
- Peak nursing home admissions remained a week after peak nursing home mortality, confirming the original finding that nursing home admissions from hospitals were not a primary driver of nursing home infections or fatalities (Updated Figure 5 – See below). Both admission and readmission data still shows that at least 98% of nursing homes already had COVID in their facility prior to admission or readmission, as evidenced by the date of report of each facility's first presumed or confirmed COVID-positive resident, COVID-related confirmed or presumed fatality, or staff.
- The comparison of the nursing home resident fatalities when including out-of-facility fatalities to community fatalities (as detailed on Report page 10) does not change the shape or interpretation of the curve and is consistent with the original analysis. (Updated Figure 2 – See below).
- Additional analyses showed that the proportion of NH fatalities in and out of the facilities compared to the community was similar in the spring and the fall/winter surge in cases: In March 2020 – May 2020 and November 2020 - Jan 2021 the proportion was approximately 35% for both time periods.

Revised charts including out-of-facility fatalities are below:

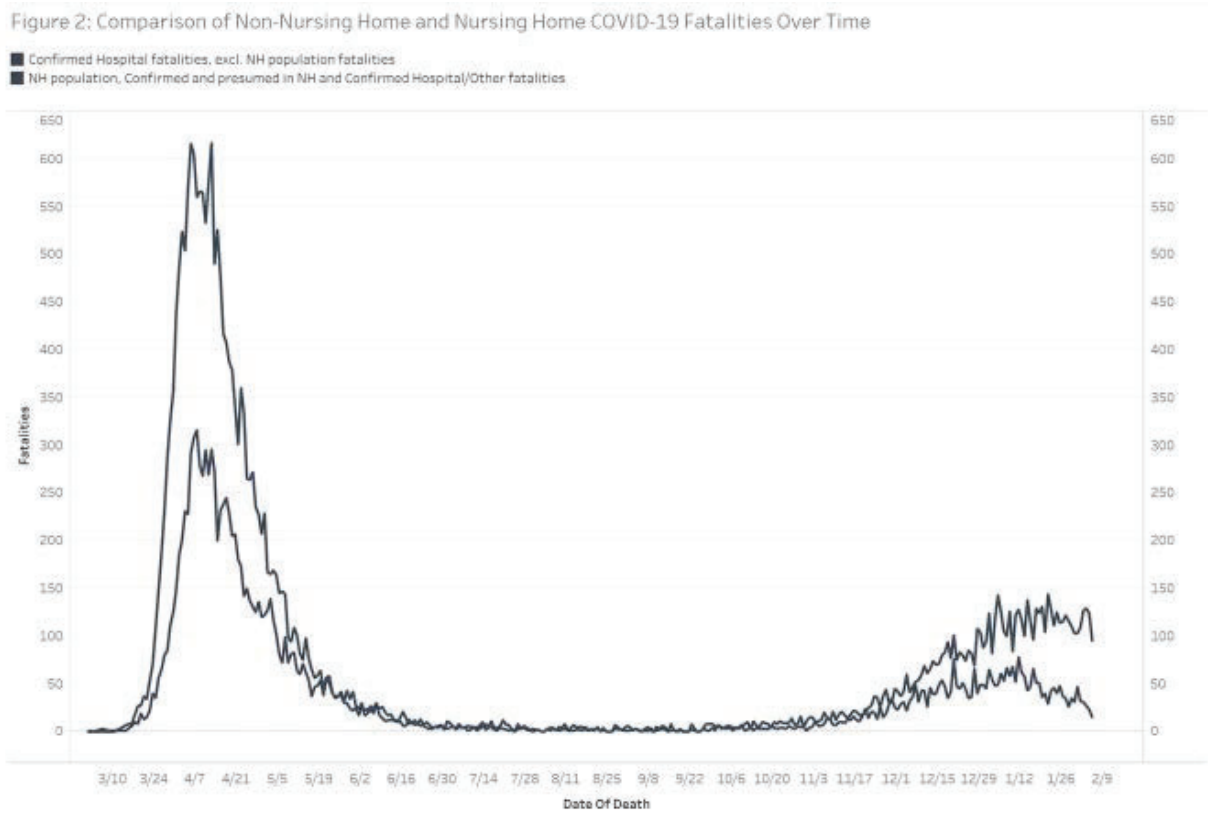


Figure 4: Number of Nursing Homes Reporting First Symptomatic Staff and Nursing Home Resident Fatalities Timeline

Figure 5: Nursing Home Fatality Curve and Admissions Over Time