Effects of the COVID-19 Public Health Emergency and the Impact of the Response on Long-Term Care Residents

Testimony on Behalf of the State Long-Term Care Ombudsman Program

Senate Health and Human Services Committee, December 8, 2020

The Office of the State Long-Term Care Ombudsman submits the following testimony to the Senate Health and Human Services Committee.

My name is Patty Ducayet. I am the State Long-Term Care Ombudsman and an employee of the Texas Health and Human Services Commission (HHSC). The Long-Term Care Ombudsman Program is located within HHSC but is independent of HHSC as we advocate for 93,000 nursing facility residents and 48,000 assisted living facility residents in Texas. As a resident-directed advocate, we investigate and resolve complaints that relate to the health, safety, welfare, or rights of a resident. We make recommendations to the Texas legislature and Congress, and to local, state, and federal agencies to improve the lives of residents. We have a role in educating the public and work to provide information to residents, their family and friends, and facility staff and owners. Our role as communicator and translator of residents' rights and facility requirements has been in high demand during the COVID-19 pandemic.

Resident Experience

"I feel like a prisoner." "There is nothing to do." "The CNAs can't keep up." "Mom was happy before and could quip her way through conversation; now her memory and joy of life is gone."

Outside of Texas's brief *stay-at-home* orders, state policies have allowed nursing and assisted living facilities the latitude to impose strict controls on resident life. We acknowledge that policies were developed to protect residents who were known to be most vulnerable to death from COVID-19. Since March, many facilities denied residents from accessing the outdoors, leaving their rooms, or leaving the facility for any reason. Residents, families, and facility

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staff call it "lockdown". This lockdown mindset is now pervasive in many facilities and the institutionalization of 30 years ago feels alive and in operation in our facilities today. We worked for decades to advance the concepts of individualized care to nursing homes and for the most part, assisted living facility care was not built from an institutionalized model, but I am deeply concerned today that as we near nine months of restricting residents' movement and their rights, we face significant challenges to restoring life in facilities and stamping out institutionalism once again.

Through conversations with residents, we've learned a lot about what it feels like to be living through this pandemic from a facility bed. Devoid of human touch and without the independent eyes and ears from advocates and visitors, some bad things have happened. Through conversations with residents' family members, we've learned what it feels like to be shut out from your connection to a person living in a facility. To experience the grief of abandoning someone because you aren't allowed in and you aren't allowed touch. The anxiety of not knowing when the virus will come for your loved one. The anger after watching a livestream or recording of your parent – seeing what care isn't being given, being helpless to do anything about it, and seeing how stressed the direct care staff seem when they walk into the room or deliver a meal. One thing that family members say repeatedly is that *they* were locked out for months, the virus still got in, and yet *visitors* are allowed only infrequent and brief visits. Family members feel blamed and after months of separation, residents deserve more.

If you want to know what family members have suffered and seen of their loved ones – and what they ask of their government – I recommend you read two reports from the family advocacy group called Texas Caregivers for Compromise. *This Baby Should Be Walking By Now* and *Saving Them To Death* provide context and illustration of the pain that their loved ones and they have experienced.

My goal for long-term care residents is full restoration of their rights. We must end the different treatment of residents from the rest of our community. Human touch must be allowed again. And we need to invest in our direct care staff and elevate and compensate fairly for their role in care.

Recommendation #1 Restore a Resident's Right to Visitors in Nursing and Assisted Living Facilities

We must ensure that residents' rights are not permanently eroded by our emergency response to a crisis. The COVID-19 pandemic led to severe restrictions on residents. Due to these restrictions, residents said they felt like they had been incarcerated and were suffering without visits from loved ones. Restrictions including time limits and scheduling of all visits must be removed as soon as safely possible to ensure residents have meaningful access to visitors that includes physical touch. Visiting without a hug or holding hands doesn't give residents needed comfort and support. During the COVID-19 pandemic and when a resident is infectious and is under isolation precautions, physical touch must be permitted with PPE used as needed to minimize the risk of transmission of COVID-19.

In addition, many family members provide extensive care to a loved one in a long-term care facility, such as daily support with eating, moving or walking, and intellectual stimulation. A person with a disability has a right to select people to support them in these activities, and the access to a support person can make or break a resident's health and well-being. The role of an essential caregiver, established by emergency rule, should be added as a resident's right in state statute and rule to ensure a resident retains access to these supports.

Finally, residents dying during the COVID-19 pandemic have experienced severe limitations on their access to visitors. Current guidance from HHSC says that a resident is only entitled to an end-of-life visit when the resident is actively dying. It is up to the facility to make this determination and notify the resident's loved ones. In some cases, the determination of a resident actively dying wasn't made in time for loved ones to say goodbye in person. In other cases, a facility wrongly restricted family, friends, or clergy from access to the resident. Survivors of these losses are needlessly suffering from rigid or inconsistent decisions about when a person was actively dying. A change in state emergency rules is urgently needed to specify a facility's obligation to allow end-of-life visiting, rather than restrict it.

Recommendation #2 Set a Minimum Number of Direct Care (CNA) Staff to Resident Ratio in Nursing Facilities

Staffing is at the center of infection control failures in nursing facilities. Even when well-trained, if there are not enough staff to perform essential tasks, the staff cannot perform their jobs, with care, and in the time allotted. As a result, residents do not receive basic care, like using a toilet, getting a bath, and brushing teeth. Keeping staff numbers low can also cause staff to rush or skip infection control practices, like washing hands before and after working with a resident. Delays in care – and neglect of care – lead to declines in health and activities of daily living, infections, and pressure injuries.

A ratio of minimum direct care staff to residents can apply to the existing requirement of "adequate staffing" to ensure a minimum standard that residents can expect for their daily care needs.

According to CMS, the national average of CNA hours per resident per day is two hours and 23 minutes; Texas averages two hours and five minutes. The federal government studied this issue and concluded that residents need four hours and six minutes of care per day – that translates to two hours and 48 minutes from a CNA, 33 minutes from an LPN, and 45 minutes from an RN. This is the minimum amount of care needed to prevent pressure ulcers, dehydration, and losing the ability to carry out daily tasks like eating, dressing, and walking. Increasing the number of CNAs is the most cost-effective way to increase staffing and improve resident care. COVID-19 exposed these long-standing weaknesses in our care system. We need to invest in CNAs and we can't rely on facilities to decide to do it on their own.

Recommendation #3 Continue HHSC Oversight of Nursing and Assisted Living Facility Infection Control

Plans of Correction

Develop clear protocols for the Enforcement operations related to plans of corrections (POCs). Training and revising policies and procedures is a standard answer a facility will give as a correction, but that doesn't systemically address the root problem. To improve the approval of POCs, we recommend that HHSC require facilities to identify and address "root cause" infection control issues,

such as insufficient staffing that results in staff not having enough time to perform proper infection control.

Continued Focus on Infection Control

We need to tackle infection control as a team, like we did with physical restraints. Recommendations related to HHSC's role in infection control regulation include:

- Continue the practice of focused infection control surveys, in conjunction with or in addition to full annual surveys.
- Use data on the prevalence of infections in the facility to investigate the efficacy of a facility's infection control efforts.
- Annually review trends in infection control compliance and needed areas of improvement.
- Examine focused control surveys conducted in 2020, including evaluation of staffing patterns.

Recommendation #4 Codify the Attorney General's ruling that required public release of facility information related to infectious diseases like COVID-19.

In the first several months of the pandemic, residents and their family members and friends were denied information about which nursing and assisted living facilities had outbreaks of COVID-19. Without this information, the public had no way to know the status of cases in a specific facility. We recommend that the Office of the Attorney General's letter ruling issued on July 6, 2020 be codified in Title 4 of the Health and Safety Code, Chapter 242 and Chapter 247, to avoid delays of critical information to the public when another public health emergency occurs.

Recommendation #5 Provide opportunity for public comment on emergency rules and waivers

HHSC promulgated several emergency rules related to long-term care facilities in response to COVID-19. Texas Government Code §2001.034, authorizes state agencies with rule-making authority to adopt an emergency rule without

prior notice or hearing if it finds there is an imminent peril to the public health, safety, or welfare. However, the law does not include an opportunity for public comment. Comments on emergency rules – even if collected after a rule is published – would help HHSC and other agencies identify problems that need correction, avoid confusing rules, improve planning for future emergency rules, and improve the public's perception of state action during an emergency. We recommend that the Texas legislature amend Texas Government Code §2001.034 to require a formal, 30-day public comment period that is initiated when the emergency rule is published.

Respectfully submitted by Patty Ducayet